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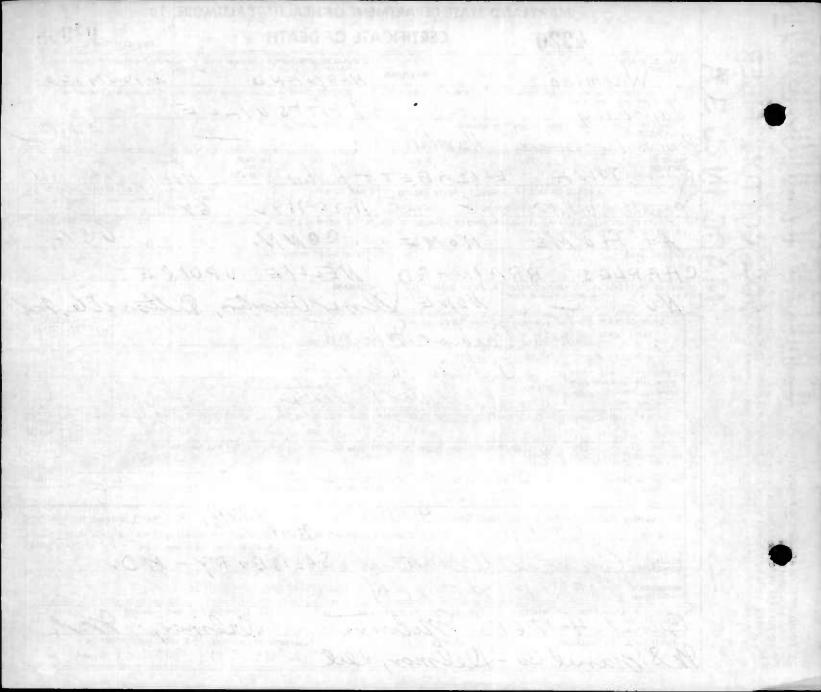
### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4920

## CERTIFICATE OF DEATH

Reg. Dist. No. 14908

| 1 | 1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY W/CU/Y/CO  |
|---|--|---|
| 1 | b. CITY OR TOWN (If autside carporate limits, write RIVRAL gnd give nearest town)  | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)  |
| 3 | d. NAME OF HOSPITAL (If not in bespitol, give street oddress) PENINSULA GENERAL HOSPITAL   | di street address  e. Is residence on a farm? Yes \( \) NO \( \)  |
|   | 3. NAME OF DECEASED (Type or print) JUL/A ELIZABETA  | 4. DATE Month Day Year OF DEATH FOLIL 14 1961   |
| 9 | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. Female White WIDOWED DIVORCED  | DATE OF BIRTH  9. AGE (In years last birthdoy)  11-26-1892  9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Manths Days Hours Min.  |
|   | 106. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  HOME  | RY 11. BIRTHPLACE (State or foreign country)  CONN  STA   |
| 3 | CHARLES BRAINARD   | NELLIE UPDIXE   |
|   | 1S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INF (Yes, no., or, miknown) (If yes, give wor or dates of service) WOIVE  | me Ouster Pettsville In   |
|   | 18. CAUSE OF DEATH [Enter only ane cause per line far (a) (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  Canditions, if any, which gave rise to immediate cause (o), stoting the under- | eralin.  Interval Between onset and Death  Onset and Death  |
|   | Iying couse last.   (c)  | IOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? |
|   |  | (Enter nature of injury in Port I or Part II of item 18.)   |
|   |  | CE OF INJURY (Hame, farm, 20f. (City ar town) (Caunty) (State) ary, street, affice bldg., etc.)   |
|   | 21. I certify that I oftended the deceosed from 4/1/6 alive on 4/1/6 19, ond that death of ACTUAL SIGNATURE 4/1/6 AR RIFE HE AR N  | 19, 19, to 4/4/6, 19, that I lost saw the deceased accurred at 9130 PM, from the causes and on the date stated above.  ADDRESS (Street, city ar tawn, state)  DATE SIGNED  D. SALISBURY - MD,   |
|   | 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR-  | n Delmar, M.  |
| 1 | 23 FUNERAL DIRECTOR'S SIGNATURE CU - Delman,   | LOL DATE APR 17'61 24b. REGISTRAR'S SIGNATURE   |



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND

CERTIFICATE OF DEATH

4922 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY Wicomico Maryland Wicomico MARYLAND c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 16 RURAL ond give Secrest town)
Salisbury Salisbury d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE OR INSTITUTION Pen Gen Hospital ON A FARMAU 615 Camdem Ave. YES NO P NAME OF Middle 4. DATE First Manth Year OF DEATH EDITH BERRYMAN APRIL MARY 61 (Type ar print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH S. SEX lost bigthday) May 28. DIVORCED X Female White WIDOWED [ YES. 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) S Employee-Women's Clothing Store Pittsburgh. 13 FATHER'S NAME Ann Catherine Bentz William Thomas Miller Mrs. Margaret M. White (Sister) Mrs. Ann Berry man Godfrey (Daughter) 615 Camden Ave. Sal-isbury, Maryland 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. No 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a DUE TO Canditions, if any, which gave rise to immediate DUE TO cause (a), stating the underlying cause lost. PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES IN NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) MEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, affice bldg., etc.) a. m While Not while ot wark at wark - 22 19 ... that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 45P the the causes and an the date stated above. and that death accurred &: saw the deceased alive an 220. SIGNATURE ATTENDING STAFF PHYS. PHYS. DIRECTOR | M.D. PEC. PHYSICIAN'S 22d. ADDRESS NAME (Type Camden Ave. Salisbury, Maryland r. Earl L. Royer 23a. BURIAL, CREMATION. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State) Burial Wicomico Mem. Park Salisbury, Maryland 1961 25b. REGISTRAR'S SIGNATURE ADDRESS 24. FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR HOLLOWAY & COMPANY arthur S. Kraus SALISBURY MARYLAND DATEAPR 1 8 '61

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### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

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|---|---|--|-----------------------------|--------------------------------------|------------------|---|----------------------------|------------------------|------------------------------|-------------|-------------|---------------------------|----------------------|
| 1 | 1. PLACE OF DEATH<br>o. COUNTY                  | Wicomico   |                             | MARY                                 | LAND             | 2. USUAL RESIDE                           | ence (Whe                  |                        | d lived. If insti<br>b. COUN |             | ence befo   |                           | on)                  |
|   | b. CITY OR TOWN<br>RURAL and give               | (If outside corporate limit nearest town). Salisbury                   | ts, write                   | c. LENGTH OF STAY                    | IN 1b            | 0. 4                                      |                            |                        | (Rura                        |             | d give ned  | arest town                | )                    |
|   | d. NAME OF HOS<br>OR INSTITUTIO                 | PITAL (If not in hospital, g   | ive street of<br>(Uni       |                                      |                  | d. STREET AD                              | D.#                        | 1                      | (Union                       | )           |             | e. IS RESI<br>ON A<br>YES | DENCE<br>FARM?<br>NO |
|   | 3. NAME OF<br>DECEASED<br>(Type or print)       | WILL   | IAM                         | Middle<br>THOMAS                     | 5                | BROWN                                     |                            | 4. DATE<br>OF<br>DEATH | ATOTOT                       | Month<br>L  | 6th         |                           | 9 61                 |
|   | s. sex<br>Male                                  | 6. COLOR OR RACE White   | 7. MARR                     | IED NEVER MARRI                      | _                | DATE OF BIRTH                             | , 18                       | 81                     | 9. AGE (In year lost birthdo |             |             | Hours Hours               | R 24 HRS.<br>Min.    |
|   | 10a. USUAL OCCUPA<br>during most of w<br>Farmer | TION (Give kind of work orking life, even if retired                   | ) - 1                       | KIND OF BUSINESS OF Farming          |                  |   |                            |                        | arylan                       | _           | U S         | WHAT C                    | OUNTRY?              |
| Ì | 13. FATHER'S NAME                               |  |                             | - HDL H                              |                  | 14. MOTHER'S A                            | AAIDEN N                   | AME                    |                              |             | 110.        |                           |                      |
| 1 |   | ney Marion   |                             |                                      |                  | 1   |                            |                        | ce Pry                       |             |             |                           |                      |
| 1 | (Yes, no, or unknown)                           | VER IN U. S. ARMED FOR<br>(If yes, give war or dates of s              | CES? 16.                    | SOCIAL SECURITY NO                   | Mr               | R.D.#1                                    | h Ta<br>(Uni               | bith on)               | a(Farī<br>Salisb             | ow)Br       | own<br>lary | (Wif                      | 'e)                  |
|   |   | DEATH [Enter only one co<br>DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (c | )/                          | te for (0), (b), and (c).<br>Lepatic | C                | inhora                                    | ,                          |                        |                              |             |             | ERVAL BET                 |                      |
|   | Conditions, if                                  |  | (                           | in gesti                             | int 1            | Kart T                                    | Tuilu                      | ıl                     |                              | 400         | -           | 6 ms                      | nthe                 |
| 1 | couse (o), stoting couse los                    | ig the under- DUE TO   | (                           | Jenerale                             | zed              | ante                                      | usi                        | elero.                 | 26                           | 1011        |             | ?                         |                      |
|   | PART II. C                                      | OTHER SIGNIFICANT CON  | DITIONS C                   | ONTRIBUTING TO DE                    | AH BUT I         | NOT RELATED TO 1                          | HE TERMIN                  | NAL DISEAS             | SE CONDITION                 | GIVEN IN PA | ART 1(o) 1  | PERFO                     | NO X                 |
|   |   | WAS UNDERLYING  NG CAUSE OF DEATH FY MEDICAL EXAMINER)                 | 20b. DESC                   | N/A                                  | CCURRED          | (Enter noture of                          | injury in Po               | ort I or Po            | rt II of item 18.)           |             |             |                           |                      |
|   | 20c. TIME OF INJ<br>Hour o. m                   | n. N/A 10  | 20d. IN<br>While<br>of work | Not while of work                    | 20e. PLA<br>foct | CE OF INJURY (He<br>ory, street, office I | ome, farm,<br>oldg., etc.) |                        | y or town) /A                |             | (County)    |                           | (Stote)              |
|   |   | hat (I) (t <del>his hospi</del> tal                                    | ) attend                    | 2 / /                                |                  | eath accurred                             | 1:25                       | M, from                | April the causes             |             |             | at (1) (4                 |                      |
|   | 220. SIGNATURE                                  | 147  | 20                          | Mais                                 |                  | .D. ATTENDING                             | MEI                        |                        | STAFF<br>PHYS.               | Apı         | cil         |                           | DATE<br>SIGNED       |
|   | 22c. PHYSICIAN'S<br>NAME (Type                  |  | T.A                         | dkins                                |                  | 22d. ADDRES                               |                            | d, M                   | arylan                       | d           |             |                           |                      |
|   | 23a. BURIAL, CREMAT<br>REMOVAL (Speci<br>BUP1   | Apr. 8, 1  | 961                         | 23c. NAME OF CEM<br>Parson           |                  | crematory                                 |                            | _                      | TION (City, tow              |             |             | (Stote                    | 2)                   |
| 4 | 24. FUNERAL DIRECTO                             |  |                             | ADDRESS                              |                  |   | 25a. REC'D                 | BY REGIS               |                              | EGISTRAR'S  |             |                           |                      |
|   | HOLLOWAY  | & COMPAN   | Y S.                        | ALISBURY                             | MAR              | YLAND                                     | DATER                      | 0 '61                  | an                           | thur S.     | traus       |                           |                      |

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FOR STATE for you Board P. is

ould be executed within 24 hours after death. If any delay "in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral. Office along with form PM3. Page 5 may be retained fo burial-transit permit. File pages 1 and 2 with the State Bo. noval, and in any event within 72 pours after death. removal, This certificate should "pending" trificate, writing the word "pending" ed to the Chief Medical Examiner's CTOR: Page 3 should be used as a ant, prior to burial, cremation, or ren please execute the prifificate, very should be forwarded to the DECTOR: Por its designated agent, prior DEPUTY OL 40 VS. A15ME 5M 7/59

I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceesed fived, If institution: Residence before edmission) a. COUNTY Wicomico b. COUNTY Maryland Wicomico MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) write RURAL end give nearest town) Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (it not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 612 Hill St Hill St YES NO X 3. NAME OF Middle 4. DATE Month Year DECEASED FLOSSIE CLARK APRIL (Type or print) MAE DEATH 61 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 49 yrs. Months Female WIDOWED [ DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) House Work at Home None Virginia IJ S 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Peter Buther Alice Mercer Mr. Milton T. Clark (Husband) 612 Hill St Salisbury, Maryland 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 16. SOCIAL SECURITY NO. (Yes, no. or unkown) i (If yes give war or dates of service) No 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c), INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Coronary occlusion IMMEDIATE CAUSE (e) Sudden DUE TO Conditions, if eny, which Acute alcoholism (b) Hours gave rise to Immediate cause DUE TO (a), steting the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? YES X NO 20e. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of injury in Pert I or Pert II of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. WEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, Month, Dey, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (State) fectory, street, office bldg., etc.) While Not While Hour e.m. et work et work 21. I certify that I took charge of the remains described above, held an Autopsy | X, Inspection Inquiry | and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE Dr. Earl L. Royer DEPUTY MEDICAL EXAMINER 407 Camden Ave. Salisbury, Md Apri] Address (Street, city, town, or county) 22e. BURIAL, CREMATION, 22c. NAME OF CEMETERY OR CREMATORY 22b. DATE THEREOF 22d. LOCATION (City, town, or country) REMOVAL (Specify) Burial Wicomico Memorial Park May 1 .1961 Salisbury, Maryland 23. FUNERAL DIRECTOR **ADDRESS** 24a. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND DAMAY 3 Circhun & Kings

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18 Film 287 5-25 MARYLAND STATE DEPARTMENT OF HEALTH

MOY TOWN TWA c D sero Dastie Solla THE REAL STATE OF THE s 10 M 10 M 1000 nortal mer i, 1961 : wicentae mecena Rark o Sellebury, de byland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIM

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|                                  | Reg. Dist    |          |              |                      |  |
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| item 18.)                        |              |          |              |                      |  |
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| TY. | 1. PLACE OF DEATH o. COUNTY  WICOM | 100                     | ml         | MARYLAND    | 2. USUAL RESIDI |
|     | b CITY OR TOWN (If outside         | corporate limits, write | C LENGTH C | ESTAY IN 16 | C CITY OF TO    |

EALTH—BALTIMORE, 18
5/1/61 iwk
EATH 04914

|   | Reg. Dist, No.  |
|---|---|
| 1. PLACE OF DEATH O. COUNTY WICOMICO MARYLANE   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY b. COUNTY |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |   |
| d. NAME OF HOSPITAL (If not in lospitol, give street oddress)  OR INSTITUTION.  | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?   |
| PENINSULA GENERAL HOSPITAL  | 1020 Lake St YES NO D   |
| 3. NAME OF DECEASED (Type or print) Ollie ( Prestow Middle  | CORBIN 4. DATE Month Day Year DEATH PRIL 18 1961  |
| 5. SEX 6. COLOR OR TACE 7. MARRIED NEVER MARRIED  | B. DATE OF BIRTH  9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.  1                                    |
| MALE CORED WIDOWED DIVORCED 100. USUA/OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INC   | 6-10-03 108/5/15  |
| during most of working life, even if retired)   | DUSTRY 11. BIRTHPLACE (Stote or foreign cauntry) 12.CITIZEN OF WHAT COUNTRY?                              |
| 13. FATHER'S NAME   | 14. MOTHER MANDEN NAME  |
| Luke Carbin.  | mesu Derens   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes, give war or dates of service)                                 | Perrie Corbin   |
| 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b) and (6).   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  | a Tremonia 200mg  |
| 260X DUE TO SUCLAF  | n. 107-2 8 11-  |
| Canditians, if ony, which gove rise to immediate DUE TO   | Mallering maga  |
| tying cause lost.   | Clarotic Heart Nisla Strokfunt  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH B  20g. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  YES NO   |
|   | RED. (Enter nature of injury in Part I or Part II of item 18.)  |
| 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Haur a. m. p. m.  19 While at work at work  | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or tawn) (County) (State)    |
| 21. I certify that I attended the deceased from / U   | 196 00 / July 18 that I last saw the deceased   |
| alive on  | oth accurred at 12.32. M, fram the causes and an the date stated above.                                   |
| ACTUAL FURNELL SIGNATURE  | M.D. 6 2 W. M.D. 18 Cycl  |
| PHYSICIAN'S<br>NAME (Type)  | Salisbury, no   |
| 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY BURIAL Specify 4-33-61 West DA  | OR CREMATORY 22d. LOCATION (City town, or county) (State)   |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  | 24a. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE   |
| 1510 111 11-000   | Clust The DATEADD 2 5 161 0 11 - 9 55 04  |

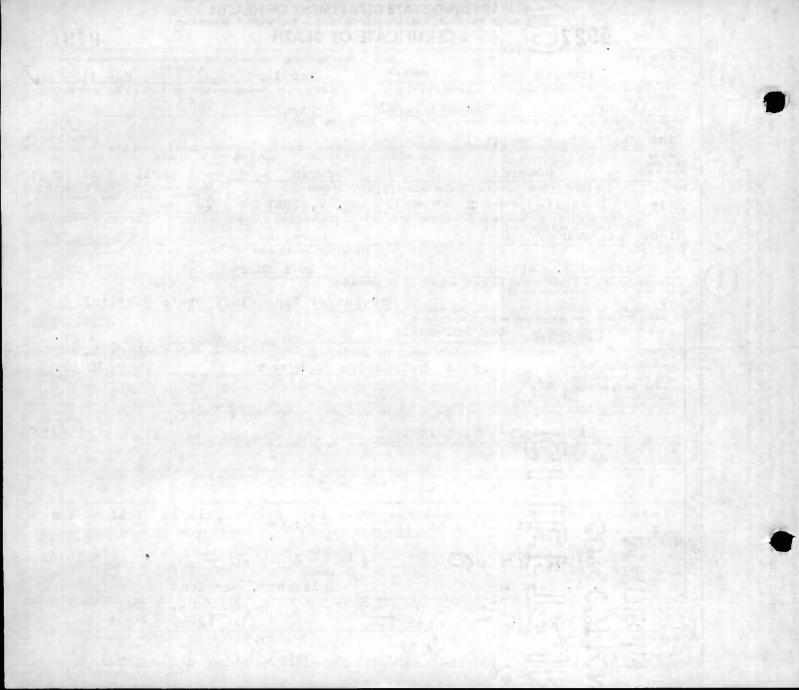
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|--------------------------|----------------------------|--------------|--------|
| al director,             | and 2 should be filed with |              | V<br>V |
| in by the                | and 2 should               |              | 0      |
| sletely filled in by the | _                          | ifter death. |        |

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

|               | 4927  | 31011 01     | CERTIF                             | CATE      | OF DEATH  | 1                      | AKT EATTO                            |                  | 04                            | 915                                |
|---------------|---|--------------|------------------------------------|-----------|---|------------------------|--------------------------------------|------------------|-------------------------------|------------------------------------|
|               | PLACE OF DEATH o. COUNTY Wicomico   |              | MARYL                              |           | USUAL RESIDENCE (Wo. STATE                        |                        | ived. If institution b. COUNTY       | -                | e before od                   | ,                                  |
|               | b. CITY OR TOWN (If outside corporate li<br>RURAL and give nearest town)<br>Salisbury                   |              | c. LENGTH OF STAY II               |           | c. CITY OR TOWN (IF                               | outside corporot       | te limits, write RI                  | URAL ond gi      | ve nearest t                  | own)                               |
|               | d. NAME OF HOSPITAL (If not in hospitol, OR INSTITUTION  Pine Bluff State                               |              |                                    |           | d. STREET ADDRESS                                 |                        |                                      |                  | 10                            | RESIDENCE<br>N A FARM?             |
|               | NAME OF<br>DECEASED   | irst<br>vard | Middle                             |           | Lost<br>Corkran                                   | 4. DATE<br>OF<br>DEATH | Mon<br>Ap                            | m<br>ril         | Day<br>14                     | Yeor<br>19 61                      |
|               | Male   6. COLOR OR RAC  | 7. MAR       | RIED NEVER MARRIE                  |           | ate of Birth                                      |                        | AGE (In years lost birthdoy) 73 yrs. |                  | YEAR IF UI<br>Doys Hou        | NDER 24 HRS.                       |
| 100           | USUAL OCCUPATION (Give kind of wor<br>during most of working life, even if retire<br>Night Watchman     | k done 10b   | KIND OF BUSINESS OR                | INDUSTRY  | 11. BIRTHPLACE (Stot                              |                        | ntry)                                | 12. CITIZ        |                               | AT COUNTRY?                        |
| 13.           | FATHER'S NAME  Richard T. Co  | orkra        | n                                  | 1         | 4. MOTHER'S MAIDEN Anne                           | Sharp                  |                                      |                  |                               |                                    |
| 1S.<br>{Ye    | WAS DECEASED EVER IN U. S. ARMED FC<br>s. no. or unknown) (If yes, give wor or doles of<br>NO           |              | SOCIAL SECURITY NO.                | 17. INFO  | rds of Pin  | ne Bluff               | Addi                                 |                  | ital                          | h. X                               |
|               | 18. CAUSE OF DEATH [Enter only one<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE                    | Co           | r Pulmonal                         | е         |   |                        |                                      |                  | ONSET A                       | BETWEEN<br>ND DEATH                |
|               | Conditions, if ony, which gove rise to immediate DUE  | (b) Ch       | ronic Obst                         | ructi     | ve Emphys   | ema                    |                                      |                  | 10 3                          | r.                                 |
| NO            | lying couse lost.  PART II. OTHER SIGNIFICANT CO  | (c)          | CONTRIBUTING TO DEA                | TH BUT NO | T RELATED TO THE TER/                             | MINAL DISEASE (        | CONDITION GIV                        | EN IN PART       | 1(o) 19. W                    | AS AUTOPSY<br>RFORMED?             |
| CERTIFICATION | Pulmon  200. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CAUSE OF DEAT (IF EITHER, NOTIFY MEDICAL EXAMINER | 20b. DE      | Cuberculosi<br>CRIBE HOW INJURY OC |           | enter noture of injury in                         | Port   or Port         | I of item 18.)                       | ay.              |                               | □ № 1                              |
| MEDICAL       | 20c. TIME OF INJURY Month, Doy, Hour o. m. 15 p. m.   | While        | Not while                          |           | OF INJURY (Home, fai<br>, street, office bldg., e |                        | r town)                              | (Ce              | ounty)                        | (Stote                             |
|               | saw the deceased alive an   | al) atten    |                                    |           | ril 13<br>4:30                                    | 961 , to Aj            | oril 14<br>ne causes an              | 19.6<br>d an the | <b>1</b> , that (<br>date sta | l) ( <b>%e</b> ) last<br>ted abave |
|               | 22c. SIGNATURE  EXPRI  22c. PHYSICIAN'S   | tele         | rien                               | M.D       | ATTENDING PHYS.                                   | MED.<br>DIRECTOR       | STAFF PHYS.                          |                  | 4/1                           | 226. DATE<br>4/61                  |
| 224           | NAME (Type) E. P. Rit   |              |                                    | TERV OR C | Salisbu   | ry, Man                | ryland                               | ar coloty        |                               | CA-4-1                             |
| 1             | REMOVAL (SPECIFY)  PUNERAL DIRECTOR'S SIGNATURE   | 1961         | 23c. NAME OF CEME                  | tos       |   | C'D BY REGISTRA        | Low                                  | STRAR'S SIG      | d                             | Stote)                             |
| 24            | A MILES MO  | 00           | for Sho                            | Lond      | 10  | 1 0 161                |                                      | SIRAR S SIG      |                               |                                    |



|                       | PLACE OF DEAT   | Fo U   | DICAL EXAMIN   |  | DENCE (Where decessed lived,   |   |                            |
|-----------------------|---|--|--|--|--|---|----------------------------|
| XI.                   | COUNTY  |  | 4  | a. STATE   | b. CO  |   | e amission)                |
| / -                   | b. CITY OR TOWN   | Wicomico (if outside corporate timi  |  | AY IN IN   | Maryland VN (If outside corporete limits, w  | Wicomico  | un)                        |
|                       | write RURAL an  | d give neerest town)   |  | 1  |  | LIIG KOKVE GIIG BIAG HEGION 104                 | v11)                       |
| -                     | d. NAME OF HOSP   | Sbury  | (if not in hospitel, give street edd   | d. STREET ADDI   | Salisbury  | l a. IS R                                       | ESIDENCE                   |
|                       | 700   |  |  |  |  | ON  | A FARM?                    |
| 3.                    | NAME OF   | N. Westo   | ver fircle   | Last   | N. Westover  | OT1070  |                            |
|                       | DECEASED<br>(Type or print)   | Ambali   |  | Cattman  | OF<br>DEATH  | 11-8-61 19                                      |                            |
| 5.                    | SEX   | Arteli,  | 7. MARRIED NEVER MARRIE  | Cottman  ED   B. DATE OF BIRTH   | 9. AGE (In year  | ers   IF UNDER I YEAR   IF UNDER                | 24 HRS.                    |
|                       | Tal   | C  | WIDOWED DIVORCE  |  | lest birthdey  | Months Deys Hours                               | Min.                       |
| 10                    | . USUAL OCCUPAT   | TION (Give kind of work  | k 10b. KIND OF BUSINESS OF   | R INDUSTRY 11. BIRTHPLACE (  | State or foreign country)  | 12. CITIZEN OF WHAT                             | COUNTRY?                   |
| do                    | Domest  | orking life, even if retire<br>っさん   | State Teach  | ners College   |  | U.S.A   |                            |
| 13                    | FATHER'S NAME   |  | Board Load.  | 14. MOTHER'S MAI   | DEN NAME   |   |                            |
| )                     | Garriso   | n White  |  | 11111  | an Dashiell  |   |                            |
|                       | WAS DECEASED EN   | VER IN U.S. ARMED FOR  |  | O. 17. INFORMANT   | Addre  | ess A A A                                       |                            |
| 1                     |   |  |  | Robert White   | 12030 ISt.   | faluler on                                      | di                         |
|                       | The second second   |  | ceuse per line for (a), (b), and (   | c).]   | 150 July 1915  | INTERVAL BE                                     | TWEEN                      |
|                       | PART I. DEAT  | TH WAS CAUSED BY: IMMEDIATE CAUSE (e)  | Brenche-pn   | eumonia  |  | Hour  |                            |
|                       | 491X  | DUE TO   |  |  |  |   |                            |
|                       | Conditions, if en   |  |  |  |  |   |                            |
|                       | geve rise to immed<br>(a), stating the  |  |  |  |  |   |                            |
|                       |   | ) (c)  |  |  |  |   |                            |
| _                     | cause lest.   |  | TIGALIC CONTENION TO BEAT  | FILE STITE A SECRET A THE TOTAL PROPERTY.  |  |   |                            |
| NOIL                  | -   |  | TIONS CONTRIBUTING TO DEAT   | TH BUT NOT RELATED TO THE TI   | RMINAL DISEASE CONDITION G   | PERFO   | DRMED?                     |
| FICATION              | PART II. OTHE   | R SIGNIFICANT CONDI  |  |  |  | PERFO   |                            |
| CERTIFICATION         | PART II. OTHE   | AUSE WAS 2   | TIONS CONTRIBUTING TO DEAT   |  |  | PERFO   | DRMED?                     |
| AL CERTIFICATION      | PART II. OTHE  20e. EXTERNAL C PRIMARY OF CO CAUSE OF DEATH   | R SIGNIFICANT CONDI  | 206. DESCRIBE HOW INJURY O   | CCURED, (Enter nature of Injury i  | n Part I or Part II of item 18.)   | YES Z   | NO [                       |
|                       | PART II. OTHE  20e. EXTERNAL C PRIMARY OF C CAUSE OF DEATH  20c. TIME OF INJI Hour a.m.   | AUSE WAS DITRIBUTING URY Month, Day, Ye  | 20b. DESCRIBE HOW INJURY OCHER   20d. INJURY OCCURRED   While Not While  |  | n Part I or Part II of item 18.)   | YES Z   | DRMED?                     |
| MEDICAL CERTIFICATION | PART II. OTHE  20e. EXTERNAL C PRIMARY OF CC CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.   | AUSE WAS 2 ONTRIBUTING 2 URY Month, Day, Yee   | 20b. DESCRIBE HOW INJURY OC<br>ier 20d. INJURY OCCURRED<br>While Not While<br>af work et work  | CCURED, (Enter nature of Injury i<br>20e, PLACE OF INJURY (Home<br>factory, street, office bldg.   | n Part I or Part II of item 18.)  , farm, 20f. (City or town) , etc.)  | YES Z   | ORMED?<br>NO               |
|                       | PART II. OTHE  20e. EXTERNAL C PRIMARY OF OF C CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.  21. I certify t  | AUSE WAS 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2   | 20b. DESCRIBE HOW INJURY OCCURRED While Not While at work et work of the remains described all   | 20e. PLACE OF INJURY (Home factory, street, office bldg  | farm, 20f. (City or town)  Inspection X. Inspection  | (County)  Lity K and in my o                    | ORMED?<br>NO               |
|                       | PART II. OTHE  20e. EXTERNAL C PRIMARY OF CC CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.   | AUSE WAS 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2   | 20b. DESCRIBE HOW INJURY OCCURRED While Not While at work et work of the remains described all   | 20e. PLACE OF INJURY (Home factory, street, office bldg.   | farm, 20f. (City or town)  J. Inspection X. Inquide, Undetermined  | (County)  Lity K and in my o                    | ORMED?<br>NO               |
|                       | PART II. OTHE  20e. EXTERNAL C PRIMARY OF C CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.  21. I certify t death resulted  | AUSE WAS 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2   | 20b. DESCRIBE HOW INJURY OCCURRED While Not While at work et work of the remains described all   | 20e. PLACE OF INJURY (Home factory, street, office bldg.  Dove, held an Autopsy, Suicide, Homic CHIEF MEDIC  | n Part I or Part II of item 18.)  farm, 20f. (City or town)  fec.)  Inspection X, Inquide , Undetermined CAL EXAMINER  | (County)  uiry And in my o                      | (State)                    |
| 1 "                   | PART II. OTHE  20e. EXTERNAL C PRIMARY OF OF CC CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.  21. I certify t death resulted  ACTUAL SIGNATURE  | AUSE WAS DITRIBUTING 2  URY Month, Day, Ye 19  hat I took charge of from: Natural ca   | 20b. DESCRIBE HOW INJURY OCCURRED While Not While at work of the remains described all auses . Accident  | 20e. PLACE OF INJURY (Home factory, street, office bldg.  bove, held an Autopsy Chief Medical Communication of the Medical Magnetic Assistant M.D. Assistant   | farm, 20f. (City or town)  J. Inspection X. Inquide, Undetermined  | (County)  uiry And in my o                      | (State)                    |
|                       | PART II. OTHE  20e. EXTERNAL C PRIMARY OF OF CC CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.  21. I certify t death resulted  ACTUAL SIGNATURE  | AUSE WAS DITRIBUTING DEPARTMENT ON THE PROPERTY OF THE PROPERT | 20b. DESCRIBE HOW INJURY OCCURRED While Not While al work of work of the remains described al auses Accident   Oyer, N.D.                                | 20e. PLACE OF INJURY (Home factory, street, office bldg.  bove, held an Autopsy Chief Medical Chief Medical Assistant Deputy Medical Control of the property Medical Chief Chief Medical Chief C | ferm, 20f. (City or town)  ferm, 20f. (City or town)  Inspection X. Inquide, Undetermined CAL EXAMINER  MEDICAL EXAMINER  DICAL EXAMINER   | (County)  uiry And in my o                      | (State)                    |
| MEDICAL               | PART II. OTHE  20e. EXTERNAL C PRIMARY OF OF C CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.  21. I certify t death resulted  ACTUAL SIGNATURE EXAMINER'S NAME (Type)  3. BURIAL, CREMATI                              | AUSE WAS ONTRIBUTING   2  URY Month, Day, Ye  that I took charge of from: Natural car  Farl J. R  107 Camda  ON, 22b. DATE THERE   | 20b. DESCRIBE HOW INJURY OCCURRED While Not While at work et work of the remains described al auses Accident auses Accident auses Accident Services Ave. | 20e. PLACE OF INJURY (Home factory, street, office bldg.  bove, held an Autopsy Chief Medical Communication of the Medical Magnetic Assistant M.D. Assistant   | ferm, 20f. (City or town)  ferm, 20f. (City or town)  Inspection X. Inquide, Undetermined CAL EXAMINER  MEDICAL EXAMINER  DICAL EXAMINER   | (County)  uiry   and in my of manner   DATE SIG | ORMED? NO (State)  (State) |
| MEDICAL               | PART II. OTHE  20e. EXTERNAL C PRIMARY OF OF CC CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.  21. I certify t death resulted  ACTUAL SIGNATURE EXAMINER'S NAME (Type)   | AUSE WAS ONTRIBUTING   2  URY Month, Day, Ye  that I took charge of from: Natural car  Farl J. R  107 Camda  ON, 22b. DATE THERE   | 20b. DESCRIBE HOW INJURY OCCURRED While Not While at work et work of the remains described al auses Accident auses Accident auses Accident Services Ave. | 20e. PLACE OF INJURY (Home factory, street, office bldg bove, held an Autopsy CHIEF MEDI-M.D. ASSISTANT DEPUTY MEE   | farm, 20f. (City or town)  Inspection X. Inquide , Undetermined  CAL EXAMINER   MEDICAL EXAMINER   DICAL EXAMINER X  get, city, town, or county)  22d. LOCATION (City, tow   | (County)  uiry                                  | ORMED? NO (State)  (State) |
| WEDICAL               | PART II. OTHE  20e. EXTERNAL C PRIMARY OF CO CAUSE OF DEATH  20c. TIME OF INJI Hour a.m. p.m.  21. I certify t death resulted  ACTUAL SIGNATURE EXAMINER'S NAME (Type)  BURIAL, CREMATI REMOVAL (Specify REMOVAL (Specify | AUSE WAS DITRIBUTING   2  AUSE WAS DITRIBUTING   2  URY Month, Day, Ye  hat I took charge of from: Natural car  Farl J. R  107 Camdo  ON, 22b. Date THERE  14/12/1   | er   20d. INJURY OCCURRED   While   Not While   at work   et work   of the remains described al auses   Accident   Accident   Oyer, ND.                  | 20e. PLACE OF INJURY (Home factory, street, office bldg bove, held an Autopsy CHIEF MEDI-M.D. ASSISTANT DEPUTY MEE   | A Part I or Part II of item 18.)  A farm, 20f. (City or town)  A Inspection X Inquide  Inquid | (County)  uiry                                  | ORMED? NO (State)  (State) |

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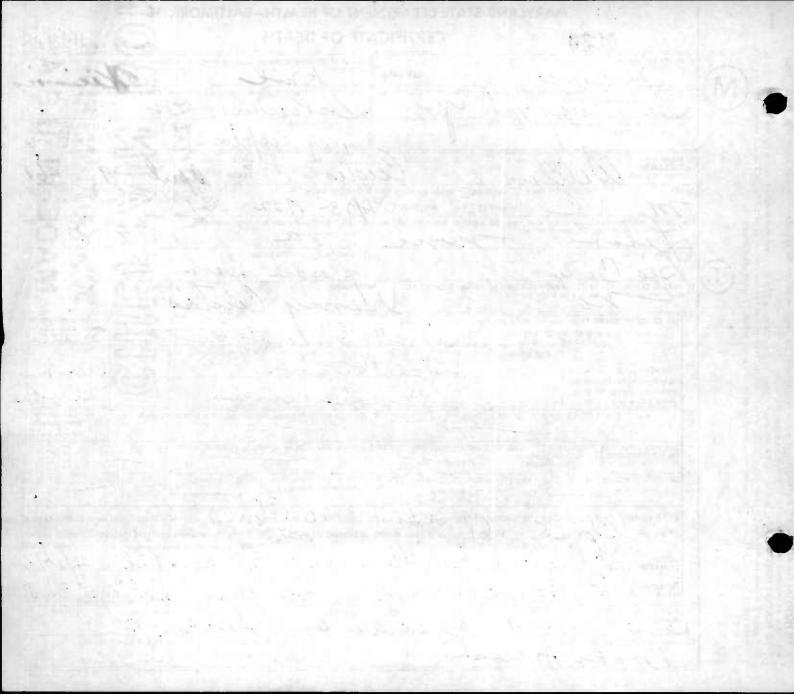
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



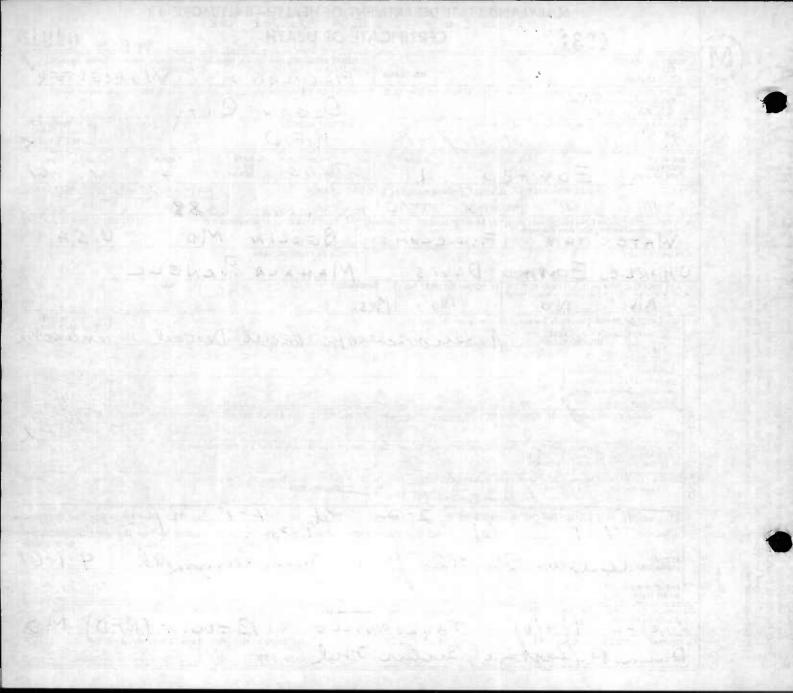
| MARYLAND<br>Item | STATI | DEP | ARTME | NT OF | HEALTH | -BA | LTIMORE. | 18 |
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4931

CERTIFICATE OF DEATH

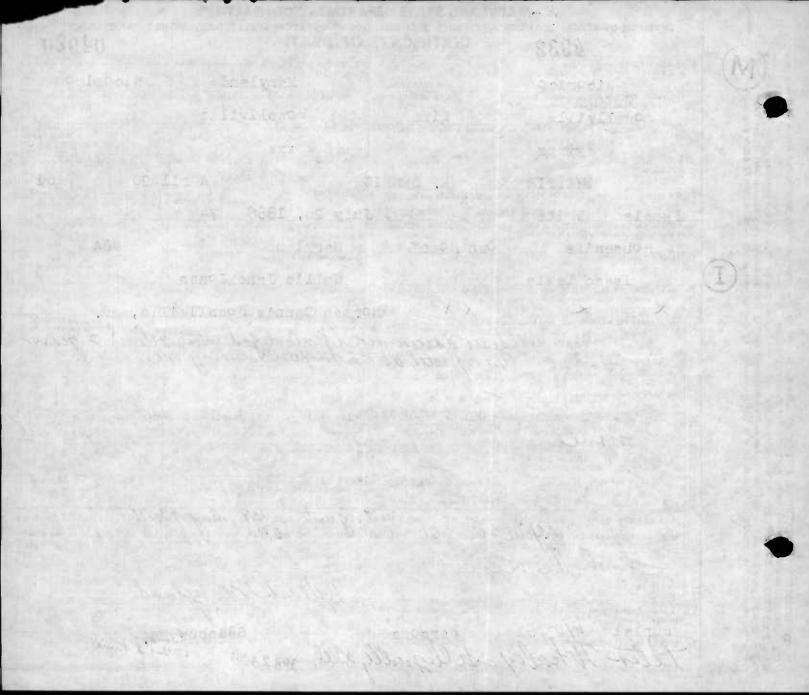
04919 Reg. Dist. No.

| 1.            | PLACE OF DEATH a. COUNTY   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  a.STATE b. COUNTY |
|---------------|--|--|
| L             | WICOMICO MARYLAND  | WARNLAND b. COUNTY ORCES TER   |
|               | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown)                                       | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                         |
|               | d. NAME OF HOSPITAL (If not in hospital, give street address)  | d. STREET ADDRESS  e. IS RESIDENCE   |
| L             | PENINSULA GENERAL HOSPITAL   | R.F.D BX-2 ON A FARM?  |
| 3.            | NAME OF DECEASED (Type or print) FIRST Middle  | DAULS 4. DATE Month Day Year OF DEATH 4 1 1961   |
| 5.            | SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED  | 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.                                       |
| 1             | m WIDOWED ▼ DIVORCED □   | May 23, 1872 88 Softy. Months Days Haurs Min.  |
| 10            | o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUduring most of working life, even if retired) | JSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?                             |
|               | WATERMAN FISH-CLAMS  | BERLIN MD USA,   |
| 13            | . FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME   |
| 1             | CHARLES EDWARD DAVIS   | MAHAZA TURNELL   |
|               |  | INFORMANT Address  |
| (1            | es. no, or unknown] [If yes, give wor or dates of service]   | RS   |
|               | 18. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and (c).]  | INTERVAL BETWEEN ONSET AND DEATH   |
|               | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) A LARGE SE  | broke beatl Descal continuen   |
|               | 420 DUE TO   |  |
|               | Conditions, if any, which ) (b)  |  |
|               | gove rise to immediate cause (a), stating the under-   |  |
|               | lying couse last.  |  |
| Z             |  | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY                       |
| Ĭ             |  | PERFORMED?   |
| CERTIFICATION | 20g. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRIOR CONTRIBUTING   CAUSE OF DEATH                        | ED. (Enter nature of injury in Part I or Part II of item 18.)  |
| CER.          | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |
|               |  | LACE OF INJURY (Home, farm, 20f. (City ar town) (County) (Stote)   |
| MEDICAL       | Hour o. m. While Nat while for me work at work   | octory, street, office bldg., etc.)  |
| 2             |  |  |
|               | 21. I certify that I attended the deceased from.   | 1901, to 4 1 last saw the deceased   |
|               | alive on, 1% of, and that death  | h accurred at 1.324M, from the causes and an the date stated above.                                      |
|               | ACTUAL 1 2 OCALA 50 5000 1   | ADDRESS (Street, city or tawn, stote)  DATE SIGNED   |
|               | SIGNATURE WILLIAM DE , ELLES   | MD. Decles elling, Md. 7-1-01  |
|               | PHYSICIAN'S<br>NAME (Type)   |  |
| 22            | o. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY C  | OR CREMATORY 22d. LOCATION (City, town, or county) (State)   |
|               | REMOVAL (Specify)  | = $0$ $0$ $0$  |
| 23            | FURTAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS  | 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE   |
| 1             | Anna A. Bustare Bulin  | DATE ADR 6 361 Continue & Known  |



| I C ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after |  | funeral  | Should | the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. |
|--|--|----------|--------|--|
| hours  |  | the      | y pu   | eath.  |
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|               | DIVISION OF                                 |   | RYLAND STAT                      |             |   |                   |                                | NT 4 AA A   | DVI.     | ANID           |                      |
|---------------|---|---|----------------------------------|-------------|---|-------------------|--------------------------------|-------------|----------|----------------|----------------------|
|               | DIVISION OF                                 |   | SEARCH AND REC                   |             | OF DEAT                                   |                   | I, BALIIMOI                    | CE I, MA    | O        | 105            | 10                   |
|               |   | 4932  | - Carrini                        |             |   |                   |                                |             | U        | # J K          | U                    |
|               | LACE OF DEATH                               |   |                                  |             | e. STATE                                  | DENCE (When       | e deceesed lived, I            | NTY         |          |                | edmission            |
|               |   | icomico   |                                  | YLAND       | A   | Jarylai           | na                             | WI          | com      |                |                      |
|               | o. CITY OR TOWN (if write RURAL and         | outside corporete limits,                         | c. LENGTH OF ST                  | AY IN 16    | CITY OR TO                                | WN (If outside    | corporete limits, wri          | te RURAL an | d give   | nearest to     | wn)                  |
|               | 17%   | lville  | Life                             |             | P   | owellv:           | ille                           |             |          |                |                      |
|               | NAME OF HOSPITA                             | AL OR INSTITUTION (if no                          | et in hospital, give street ed   | dress)      | d. STREET ADD                             | RESS              |                                |             |          |                | RESIDENCE<br>A FARM? |
|               |   | XXXXX   |                                  |             |   | XXX               |                                |             |          |                | NO                   |
|               | NAME OF<br>DECEASED                         | First   | Middle                           |             | Last                                      | 4. DAT            | TE Mon                         | th          | Day      | Ye             | er                   |
|               | Type or print)                              | HETTIE  | E. D                             | ENNIS       |   | DEA               | APri                           | 1 20        |          |                | 61                   |
| 5.            | SEX   | 6. COLOR OR RACE 7.                               | MARRIED NEVER MARR               | IED B.      | DATE OF BIRTH                             |                   | 9. AGE (In yeer last birthdey) |             | 1 YEAR   |                | R 24 HRS.            |
|               | Female                                      | White w   | IDOWED DIVOR                     | ED 🔲 J      | ulv 28.                                   | 1886              | 74 yrs.                        | Months      | Days     | Hours          | Mln.                 |
| 10e.          | USUAL OCCUPATION                            | ON (Give kind of work king life, even if retired) | 106. KIND OF BUSINESS            | OR INDUSTRY |   | County & State    | , or foreign country           | 12. CI      | TIZEN O  | F WHAT         | COUNTRY              |
|               | House                                       | 1.0   | Own Home                         |             | Marvla                                    | and               |                                |             | USA      |                |                      |
| 13.           | FATHER'S NAME                               |   |                                  |             | 14. MOTHER'S MA                           | IDEN NAME         |                                |             |          |                |                      |
|               | Isa   | sc Lewis  |                                  | 25          | Sallie                                    | Jane              | Jones                          |             |          |                |                      |
| 15.<br>(Ye:   | WAS DECEASED EVEL                           | R IN U.S. ARMED FORCES                            | 7 16. SOCIAL SECURITY            | NO. 17. II  | NFORMANT                                  |                   | Addre                          | 55          |          |                |                      |
|               | X   | X   | XX                               | No          | orman Dei                                 | nnis P            | Owellvi                        | lle.        | Mđ.      |                |                      |
|               |   | 4   | se per line for (e), (b), end    | (c).        |   | 1                 | 1                              |             | INT      | ERVAL BI       |                      |
|               |   | MAS CAUSED BY:                                    | deno corce                       | um          | algene                                    |                   | antestin                       | Heiser      | ) 3      | 2 40           | ass                  |
|               | 152   | Q DUE TO /  | was operated                     | at F        | 6. Hropa                                  | tal Juls          | bury m                         | (1)         |          |                |                      |
|               | Conditions, il any,                         | 1-1   | yac yacare                       | GCN .       |   |                   |                                |             |          |                |                      |
|               | geve rise to immedia<br>(e), steting the un | DITE TO   |                                  |             |   |                   |                                |             |          |                |                      |
|               | ceuse lest.                                 | (c)   |                                  |             |   |                   |                                | 71 1/3      |          |                |                      |
| NO<br>O       | PART II. OTHER                              | SIGNIFICANT CONDITION                             | NS CONTRIBUTING TO DEA           | TH BUT NO   | T RELATED TO THE T                        | ERMINAL DISEA     | ASE CONDITION G                | VEN IN PAR  | T 1(e) 1 | 9. WAS<br>PERF | AUTOPSY<br>ORMED?    |
| EAS           | n   | me.   |                                  |             |   |                   |                                |             |          | YES            | NO Z                 |
| CERTIFICATION | 200. ACCIDENT WA                            |   | b. DESCRIBE HOW INJUR            | OCCURED.    | (Enter neture of inju                     | ry in Parl I or P | ert II of item 1B.)            |             |          |                |                      |
| - 4           | (IF EITHER, NOTIFY                          | MEDICAL EXAMINER                                  |                                  |             |   |                   |                                |             |          |                |                      |
| MEDICAL       | 20c. TIME OF INJUR                          | Y Month, Day, Year                                | 20d. INJURY OCCURRED             |             | CE OF INJURY (Homory, street, office bldg |                   | (City or town)                 | (Co         | unty)    |                | (State)              |
| MED           | Hour e.m.                                   | 19  | while Not While et work all work | 100.0       | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |                   |                                |             | -        |                |                      |
|               | 21. I certify th                            | at (I) (this hospital)                            | attended the deceas              | ed from     | naust                                     | 1959              | 10. aay. 17.0                  | Cellery     |          | hat (I)        | (we) la              |
|               |   |   | 20 1961                          |             |   |                   |                                |             |          |                |                      |
|               | 22e. SIGNATURE                              | 1 01.   |                                  |             |   | /                 | -                              |             |          |                | b. DATE              |
|               | -thear                                      | ik Lewis  |                                  | M.          | D. PHYS.                                  | MED.<br>DIRECTOR  | STAFF PHYS.                    |             |          |                | SIGNE                |
|               | 22c. PHYSICIAN'S                            |   |                                  |             | 22d. ADDRESS                              | 10                |                                | 0           |          |                |                      |
|               | NAME (Type)                                 |   |                                  |             | willa                                     | rds /             | Maryla                         | ud.         |          |                |                      |
| 23e           | BURIAL, CREMATIC                            | ON, 236. DATE THEREO                              | F 23c. NAME OF                   | CEMETERY C  | OR CREMATORY                              | 23d. L            | OCATION (City, I               |             | ty)      | (              | Stete)               |
|               | REMOVAL (Specify) Burial                    | 4/23/67   | 0                                |             |   |                   | -7-1                           | 4277        |          |                |                      |
| 24            | FUNERAL DIRECTOR                            |   | ADDRESS                          | 113         | 256                                       | . REC'D BY RE     | gurb Ara                       | HISTRAR'S   | SIGNA    | TURE           |                      |
|               | Titen                                       | Mohales   | 1 Sillier                        | -40/11      | Nel DA                                    | IDR 2 4 '6        | 1 and                          | Lun S. 9    | Valva    |                |                      |
|               | 1000  | 10000   | - Service                        | V           |   | Ther              |                                |             |          |                |                      |

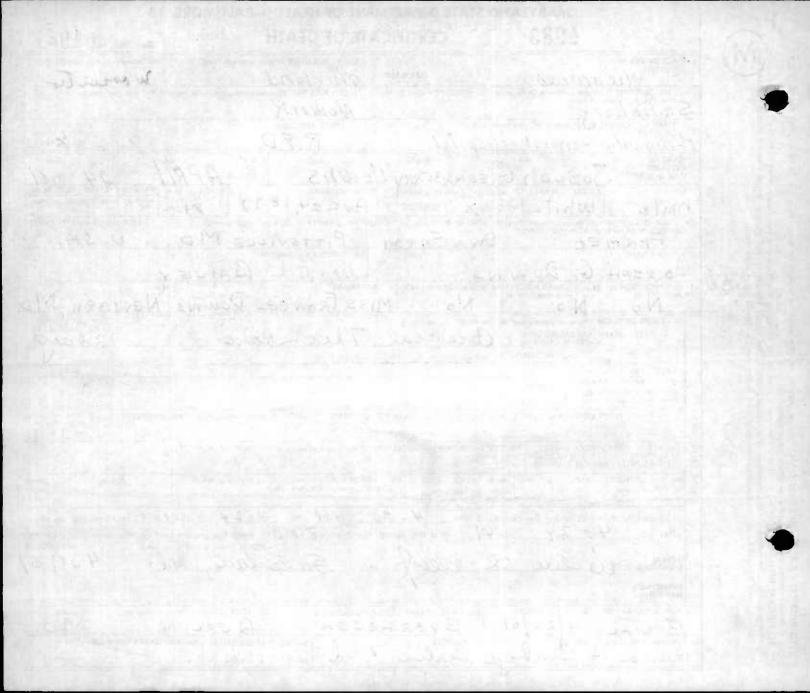


Circher S. Flrance

that the death certificate be

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| MARYLAND | STATE DEPARTMENT | OF HEALTH—BALTIMORE, | 18 |
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|                                     | 493   | L            | CEKI               | IFICA     | TE OF DI                              | EAIH         |               |                                     | Reg. D     | ist. No.    | 04                       | 1922      |
|-------------------------------------|---|--------------|--------------------|-----------|---------------------------------------|--------------|---------------|-------------------------------------|------------|-------------|--------------------------|-----------|
| 1. PLACE OF DEATH<br>D. COUNTY      | comico  |              | MAR                | YLAND     | 2. USUAL RESIDE<br>o. STATE<br>Mary 1 |              | ere deceased  | lived. If instituti b. COUNTY W1CON | 41.41      | nce befor   | e odmiss                 | ion)      |
| b. CITY OR TOWN (                   | If outside corporate lim                        | its, write   | c. LENGTH OF STAY  | IN 1b     |                                       |              | utside corpor | ote limits, write R                 |            | give nea    | rest lowr                | 1)        |
| RURAL ond give n                    |   |              | 50 year            | g         | Salis                                 | bury         | 7             |                                     | 13         |             |                          |           |
| d. NAME OF HOSPIT<br>OR INSTITUTION | 1103 E. Ch                                      |              | address)           |           | d. STREET ADI                         | DRESS        | ırch          | St.                                 | 1          |             | e. IS RES<br>ON A<br>YES | PARM?     |
| 3. NAME OF                          | Fi  | irst         | Middle             |           | Last                                  |              | 4. DATE       | Mor                                 | ıth        | Day         |                          | Yeor      |
| (Type or print)                     | Nigre   | raret        | H.                 | 1         | ryden                                 |              | OF<br>DEATH   |                                     | ril        | 18          |                          | 19 61     |
| S. SEX                              |   |              | NED NEVER MARR     | ED T      | . DATE OF BIRTH                       |              |               | 9. AGE (In years                    | IF UNDE    |             |                          | R 24 HRS. |
| female                              | white   | WIDOW        |                    |           | Dec. 7.1                              | 910          | 1000          | lost birthdoy) 50 yrs.              | Months     | Days        | Hours                    | Min.      |
| 10a. USUAL OCCUPATIO                | ON (Give kind of work                           | done 10b.    |                    |           |                                       |              | or foreign co |                                     | 12. C      | ITIZEN O    | F WHAT                   | COUNTRY   |
| Office Wo                           | king life, even it refire                       | 3)           | Offied             |           | Merv                                  |              |               |                                     |            | U.S.        | A .                      |           |
| 13. FATHER'S NAME                   | FKGF  |              | VIII.              |           | 14. MOTHER'S M                        |              | -             |                                     |            | 7.0.        | 44.0                     |           |
| Walter                              | humphrevs                                       |              |                    |           | Modd                                  | 1. 1         | Cayfi         | -14                                 |            |             |                          |           |
| 15. WAS DECEASED EVE                |   |              | SOCIAL SECURITY NO | ), 17, IN | FORMANT                               | 126 1        | Derlit        | Add                                 | ress       |             |                          |           |
| [Yes, no. or unknown)               | [If yes, give wor or dates of                   | service)     | 9-07-276           | Mng       | Jemes                                 | Hur          | Aπ            | Salish                              | 112277     | Md          |                          |           |
| IR CAUSE OF DEA                     | ATH [Enter only one c                           |              |                    |           | Valles                                | nui 3        | LOY           | Dalibe                              | U.I. y     |             | RVAL BE                  | TWEEN     |
|                                     | TH WAS CAUSED BY:                               | (            | /.                 | +         | blears                                | 1            | 11            |                                     |            | ONS         | DAND                     | DEATH     |
| 1120                                | IMMEDIATE CAUSE                                 | ,            | many lls           | JE M      | 1 years                               |              | year.         |                                     |            | 0           | mi                       | n/ in     |
| 9201                                | DUE TO  | 1            | marie a            | 10/       | W                                     | - 04         | 0             |                                     |            |             | -                        |           |
| Conditions, if o                    | mmediate  | b)           | -OYONASO           | 10        | court                                 | acc          | 4-00          | 2                                   |            |             |                          |           |
| coese (o), stoting                  | the under-                                      | 0            | (/                 |           |                                       |              |               |                                     |            |             |                          |           |
| lying couse lost.                   | HER SIGNIFICANT COI                             | c)           | CONTRIBUTING TO DE | ATU DUT A | NOT BELATED TO T                      | WE TERMIN    | IAL DISEASE   | COMPITIONS                          | C          | OT 14. 1 14 | 2 14/45                  | VIROREY   |
| ICATIO                              |   |              | LONTRIBUTING TO DE | AIN BUT   | NOT REDATED TO T                      | ME LEKMIN    | ANT DISEASE   | CONDITION GIV                       | EN IN PA   | KI 1(0) 13  | PERFO                    | RMED?     |
|                                     | AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER) | 20b. DES     | CRIBE HOW INJURY O | CCURRED   | . (Enter noture of i                  | injury in P  | ort I or Port | If of item 1B.)                     |            |             |                          |           |
|                                     | RY Month, Doy, Yo                               | 1            | NJURY OCCURRED     | 20e. PLA  | CE OF INJURY (Ho                      | ome, form,   | 20f. (City    | or town)                            |            | (County)    | P ==                     | (Stote)   |
| Hour a.m.<br>p. m.                  | 19  | While of wor | k ot work          | laci      | ory, sireer, office b                 | olog., etc.) | ,             |                                     |            |             |                          |           |
|                                     | at I attended the                               | deceas       | ed from July       | 7         | 1960                                  | 10 4         | 1/10          | 196                                 | shat I     | Inch on     | Aba                      | d         |
| alive on 4/                         | 16  | 196          | and the            | death     | occurred gh.7                         | 30 p         | M Fram        | the course                          | and on     | the det     | w me                     | decease.  |
| 1                                   | 1 11  | 5            | Culla Isali        | deoin     | occorred det                          | 0            | LOORESS VSI   | eet, city/or town,                  | stote)     | me dai      | e state                  | TE AIGNE  |
| ACTUAL                              | land X  | Tele         |                    |           | Sali                                  | skle         | in the        | -1.                                 |            | 41          | 21                       | 161       |
| SIGNATURE                           | 1/  |              |                    | ^         | 1.D.                                  |              | 1             |                                     |            |             |                          |           |
| PHYSICIAN'S<br>NAME (Type)          | 0   |              |                    |           |                                       |              |               |                                     |            |             |                          |           |
| 220. BURIAL, CREMATIC               | ON, 226. DATE THERE                             | QF .         | 22c. NAME OF CEM   | ETERY OR  | CREMATORY                             |              | 22d. LOCATI   | ON (City, town,                     | or county) |             | (Stote                   | e)        |
| REMOVAL (Specify)                   |   | 067          |                    |           | 0                                     |              |               |                                     |            |             | (3.016                   | ,         |
| 23. FUNTERAL DIRECTOR               |   | 701          | ADDRESS            | drew      | ,                                     | Ma PEC'D     | BY PEGISTE    | AR 24b, REGIS                       |            |             | E                        |           |
| Leine                               | 2.11/:82  | 101          | Princess           | Ann       | e. Md.                                | NATE -       | 0 4 104       |                                     |            |             | 170                      |           |
| COUPTOI                             | 11/1/10   | 00           |                    |           | ,                                     | WINDS        | 74 61         | - Oct                               | hur &      | Theres      |                          |           |

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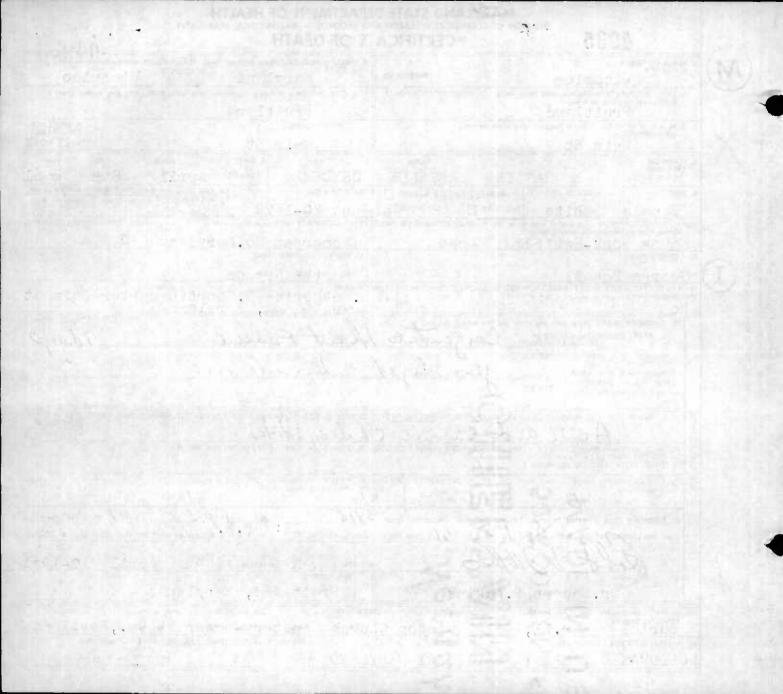
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### MARYLAND STATE DEPARTMENT OF HEALTH

SALTIMORE 1, MARYLAND

| 4935                     |            | ND RECORDS — BALTIMORE 1, MARYLAND TE OF DEATH                            | 0402 |
|--------------------------|------------|---|------|
| PLACE OF DEATH o. COUNTY | AZARVIANO. | 2. USUAL RESIDENCE (Where deceased lived. If institute a. STATE b. COUNT) |      |

| o. COUNTY Wicomico  | MARYLAND                          | a. STATE Mary                | land                   | b. COUNTY                      | Wico           | mico                                    |
|---|-----------------------------------|------------------------------|------------------------|--------------------------------|----------------|---|
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland                          | c. LENGTH OF STAY IN 1b           | Frui                         | outside corpora        | te limits, write RI            | URAL ond give  | nearest town)                           |
| d. NAME OF HOSPITAL (If not in hospital, give street or INSTITUTION  Main St  | address)                          | d STREET ADDRESS Main        | St                     |                                |                | e. IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3. NAME OF First DECEASED (Type or print) MATTE,  | Middle<br>ESTELLE                 | Lost<br>DRYDEN               | 4. DATE<br>OF<br>DEATH | April                          | њ<br>8t        | Day Yeor                                |
| 5. SEX   6. COLOR OR RACE   7. MARR Female   White   WIDOWE   | RIED NEVER MARRIED                | B. DATE OF BIRTH  June 20-18 |                        | . AGE (In years lost birthday) |                | AR IF UNDER 24 HR                       |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. during most of working life, even if retired) House Work-Retired | None                              | Somerset                     | ar foreign cou         |                                |                | OF WHAT COUNTRY                         |
| 13. FATHER'S NAME George Powell   |                                   | Martha D                     | ryden                  |                                |                |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give wor or dates of service)           | SOCIAL SECURITY NO. 17.1          | rs.Katherin<br>Fruitlan      |                        |                                | üghter         | ·)Main S                                |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  | on garfus                         | Heart Fo                     | ilees                  |                                | C              | NTERVAL BETWEEN POSET AND DEATH         |
| Conditions, if ony, which gave rise to immediate DUE TO   | Jeneralized                       | afeur                        | ders                   | ران ا                          |                | ? '                                     |
| couse (a), stating the <u>under-</u>   lying couse last. (c)   PART II. OTHER SIGNIFICANT CONDITIONS C              | CONTRIBUTING TO DEATH BU          | T NOT RELATED TO THE TERM    | INAL DISEASE           | CONDITION GIV                  | EN IN PART 1(c | 19. WAS AUTOPS                          |
| Acute and 200. ACCIDENT WAS UNDERLYING [ 20b. DESC  | Chronie (CRIBE HOW INJURY OCCURRI | Lall Cig S 7:                |                        | l af item 1B.)                 |                | YES NO                                  |
| OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | NJURY OCCURRED 20e. Pl            | LACE OF INJURY (Home, form   | n,   20f. (City o      | or town)                       | (Coun          | ty) (Stat                               |
| Hour a.m. N/A 19 While of wor   | Not while fo                      | N/A                          |                        | N/A                            | (200.          |   |
| 21. I certify that (I) (this hospital) attends  |                                   | death occurred of            | GD ta S<br>M, from f   | pil 8 he couses an             |                | that (I) (we) lo                        |
| 22a. SIGNATURE John TOUL  |                                   | M.D. ATTENDING M. M.D. PHYS. | ED.                    | CTAFF                          | April          | 22b. DATE<br>SIGNE<br>10-196.           |
| 22c. PHYSICIAN'S<br>NAME (Type)<br>Dr. Robert T. Ad   | lkins                             | 22d. ADDRESS<br>Fruitla      | nd, Ma                 | ryland                         |                |   |
| 23d. BURIAL, CREMATION, REMOVAL (Specify) Apr.ll,1961   | 23c. NAME OF CEMETERY C           | or crematory<br>hurch Cemet  |                        | on (City, tawn, comerset       |                | (State)<br>Naryland                     |
| 24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SA  | ADDRESS ALISBURY MAR              |                              | PR 1 3 '6              |                                | STRAR'S SIGNA  |   |



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| 7   | artific | led t  | CIC    | ent,   | ì |
| DEPUTY MED. AL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is me any, | he ce   | Ward   | IRE    | or its designated agent, prior to burial, cremation, or removal, and in eny event within 72 hours effer death. |   |
| MI  | If ett  | for    | L D    | pated  |   |
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MARYLAND STATE DEPARTMENT OF HEALTH

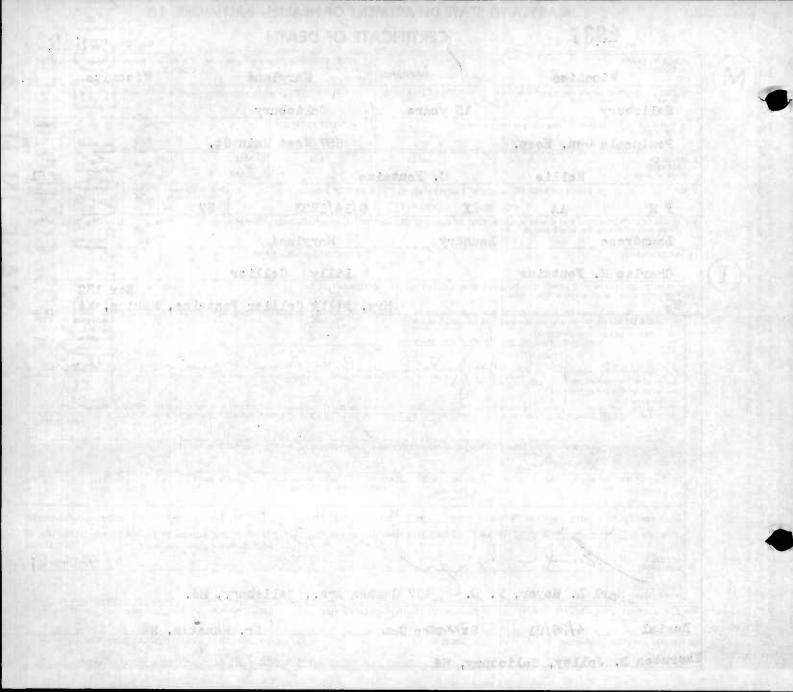
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
4936 MEDICAL EXAMINER'S CERTIFICATE OF DEATH MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01031

| 201  | It                              | em 8 Film G286                        | 5/5/61 iwk   | 112367   |
|--|---------------------------------|---------------------------------------|--|--|
| 1. PLACE OF DEATH  •. COUNTY                                     |                                 |                                       |  | b. COUNTY  |
| Wico   | mico                            | MARYLAND                              | •. STATE Maryl                                       | and Wicomico                                     |
| b. CITY OR TOWN (if  | outside corporate limits.       | c. LENGTH OF STAY IN 16               |  | orate limits, write RURAL end give neerest town) |
| write RURAL and g  |                                 |                                       | Heb  | ron  |
| d. NAME OF HOSPITA   |                                 | not In hospitel, give street eddress) | d. STREET ADDRESS                                    | •. IS RESIDENCE                                  |
|  |                                 |                                       |  | ON A FARM?                                       |
|  | P: .                            | ****                                  |  | YES NO   |
| 3. NAME OF<br>DECEASED   | First                           | Middle                                | Last 4. DATE OF                                      | Month Day Yeer                                   |
| (Typa or print)  | Julia                           | Jane Ell                              | iott DEATH   | 4-24-61 19                                       |
| 5. SEX   | 6. COLOR OR RACE 7.             | MARRIED NEVER MARRIED                 | A 1941 SEPTE . 1871 9.                               | AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.   |
| Tan I  | TAT                             | WIDOWED TO DIVORCED                   | MODERAL 1215/1961                                    | 80 yrs. Months Deys Hours Min.                   |
| 10a. USUAL OCCUPATIO   | YV.                             | 106. KIND OF BUSINESS OR INDUSTI      | RY   11. BIRTHPLACE (Stelle or foreign cour          |  |
| done during most of work   | ing life, even if relired)      | own home                              |  |  |
| Housewife  |                                 | own home                              | Delaware   | USA  |
| 13. FATHER'S NAME  | 17                              |                                       | 14. MOTHER'S MAIDEN NAME                             |  |
| John   | H. Elliott                      |                                       | Ada Wrigh  | t  |
| 15. WAS DECEASED EVEL  |                                 |                                       | INFORMANT  | Address  |
| (Yes, no, or unkown) (If)  | es à l'Ae me Lot de les ot selv | none                                  | Mrs. L. H. Hall,                                     | Hehron Maryland                                  |
|  | ATH (Enter only one or          | use per line for (a), (b), and (c).]  | Made De IIe IIdaaa,                                  | I INTERVAL BETWEEN                               |
|  | WAS CAUSED BY:                  | (1)                                   |  | ONSET AND DEATH                                  |
|  | MEDIATE CAUSE (a)               | Bronchiectasis                        |  | Months   |
| 1 4 2 6  | DUE TO                          |                                       |  |  |
| 0,0  |                                 |                                       |  |  |
| Conditions, if any,<br>gave rise to immedie                      | 10/                             | Arterio-sclero                        | tic cardio-vascu                                     | lar disease Years                                |
| (e), stating the un-   | > DUE TO                        |                                       |  |  |
| cause last.  | ) (c)                           |                                       |  |  |
| Z PART II. OTHER   |                                 | ONS CONTRIBUTING TO DEATH BUT NO      | OT RELATED TO THE TERMINAL DISEASE C                 | CONDITION GIVEN IN PART 1(a)   19. WAS AUTOPSY   |
| OF .   |                                 |                                       |  | PERFORMED?                                       |
| 2  | 155 1445                        | DESCRIPT HOW MINING COURSE            | for a series of interesting the Book I or Book II of |  |
| PART II. OTHER  20e. EXTERNAL CAL PRIMARY Or CON CAUSE OF DEATH. |                                 | . DESCRIBE HOW INJURY OCCURED.        | Enter nature of injury in Part I or Part II of       | item 10.)  |
|  |                                 |                                       |  |  |
| 20c. TIME OF INJUR   | Y Month, Day, Year              |                                       | ACE OF INJURY (Homa, farm, 20f. (City                | or town) (County) (State)                        |
| Hour a.m.  |                                 | While Not While tec                   | tory, street, office bldg., etc.)                    |  |
|  | 19                              |                                       |  |  |
| 21. I certify tha  | it I took charge of             | the remains described above, he       | eld an Autopsy , Inspection                          | Inquiry A and in my opinion                      |
| death resulted fr  | om: //Natural caus              | ses X , Accident , Suid               | cide , Homicide , Und                                | determined manner                                |
|  | 6 0.                            |                                       | CHIEF MEDICAL EXAMINER                               |  |
| ACTUAL   | 1/max                           | L 1(-)                                | ASSISTANT MEDICAL EXAMINE                            | PATE SIGNED                                      |
| SIGNATURE  | 77 7 7                          |                                       | M.D.   | 1 01 (2  |
| EXAMINER'S   | Earl L. R                       | loyer, M.X.                           | DEPUTY MEDICAL EXAMINER                              |  |
| NAME (Type)  | 407 Camde                       |                                       | Ty Addes (Street, city, town, or c                   |  |
| 22a. BURIAL, CREMATION<br>REMOVAL (Specify)                      | 1, 226. DATE THEREO!            | 22c. NAME OF CEMETERY O               | R CREMATORY 22d. LOCAT                               | ION (City, town, or country) (State)             |
| 1 ( )  |                                 |                                       |  |  |
| burlal   | 4/27/61                         | Odd Fellows C                         |  | rel, Del.  |
| 23. FUNERAL DIRECTOR   |                                 | Odd Fellows C                         | emetery Lau  | AR   246. REGISTRAR'S SIGNATURE                  |
|  |                                 |                                       | emetery Lau  | AR   246. REGISTRAR'S SIGNATURE                  |

DUE TOWN IN THE TAXABLE AT LAST SEE AND AS A TOTAL TO SEE AND A SECOND SECTION DESCRIPTION OF THE PARTY OF TH INTO BEEN ALTERNATION ns vends common and the carriers S. Budeel Concret . a college be been arrow to the set in the larger was from a force one a trainer. THE PERSON OF TH teros astronos de la compansión de la co

# al director, DING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 TO HOSPITAL OR ATTAUDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after degree retained by hospital ar attending physician. TO FUNERAL DIRECTO A After this certificate has been signed by the attending physician and campletely filled in by the funeage 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should the registrar prior to burial, cremation, ar remayal, and in any event within 72 haurs after death.

|                       |  | MINICI   | LA: 10 .   |  |  | ENT OF HEALT   |  |  |                           |   |                                   |
|-----------------------|--|--|--|--|--|--|--|--|---------------------------|---|-----------------------------------|
|                       | 4  | 937  |  | CER  | TIFICA   | ATE OF DEAT  | Н  |  | Reg. Di                   | ist. No.                                | 492                               |
| 1. P                  | LACE OF DEATH  | icomico  |  | M  | ARYLAND  | 2. USUAL RESIDENCE (Wary   |  | l lived. If institu<br>b. COUNT  | Y                         | nce before a                            | dmissian)                         |
| Ь                     | RURAL and give ne  |  | nits, write  | c. LENGTH OF ST  |  | CITY OR TOWN (IF   |  | rate limits, write   | RURAL ond                 | give nearest                            | town)                             |
| d                     | OR INSTITUTION   | AL (If not in hospital,<br>a Gen. Hos  |  |  | . 5  | d. STREET ADDRESS  |  |  | -5                        |   | S RESIDENCE<br>ON A FARM?         |
|                       | NAME OF<br>DECEASED<br>Type or print)  |  | irst   |  | ddle<br>Fontai                                 | Last   | 4. DATE<br>OF<br>DEATH   | Мо   | inth                      | Doy<br>22                               | Year                              |
| i. S                  | EX   | 6. COLOR OR RACE   |  | D NEVER MA   |  | 8. DATE OF BIRTH   |  | 9. AGE (In years<br>last birthday)   | IF UNDER                  | YEAR IF                                 | 19 61<br>UNDER 24 HR<br>Durs Min. |
| )a.                   | T M  USUAL OCCUPATION  | N (Give kind of work   | WIDOWED  |  | _  | 9/14/1923<br>STRY 11. 8IRTHPLACE (State  | e or foreign co  | 37 yrs   |                           | IZEN OF WE                              | HAT COUNTR                        |
|                       | Laundres FATHER'S NAME   | ing life, even it refired  | d)   | undry  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,        | Marylan  | d  | · · · · / /  | 12.01                     | TEN OF WE                               |                                   |
| J. 1                  |  | W Wanted-  |  |  |  |  |  |  |                           |   |                                   |
| (Yes,                 | WAS DECEASED EVE   | H. Fontain R IN U. S. ARMED FOI If yes, give wor or dates of   | RCES? 16. SC   | OCIAL SECURITY   |  | NFORMANT   | ollier   |  |                           | x 132                                   |                                   |
|                       | 74.0   |  |  |  |  |  |  | ntaine.  | WATT                      | AN MA                                   |                                   |
| _                     | 18. CAUSE OF DEA   | TH [Enter only one o   | ouse per line  | far (a), (b), and  |  | s. Lilly Col   | TTel Le  |  | TIGIT I                   |   |                                   |
| _                     |  | TH [Enter anly one of  |  | far (o), (b), and  |  | B. DITIE COL   | 1101 10  | 20021101   | ridi I                    |   |                                   |
| _                     | 942X   | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (  DUE TO  | o) U   | far (o), (b), and  | (c).]  |  |  |  | , all                     |   | AL BETWEEN AND DEATH              |
| _                     |  | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (i  DUE TO  ny, which (I) mmediate   | (o) U  | far (o), (b), and  | (c).]  | . C.J. Le  |  |  |                           |   |                                   |
|                       | Canditions, if all gave rise to in cause (a), stating lying cause last.  | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (  DUE TO  ny, which  mmediate  the under-   | (c) U  | ngata  | (c).]  |  | _22_   | men  |                           | INTERV.<br>ONSE)<br>20                  | AL BETWEEN AND DEATH              |
| CATION                | Canditions, if all gave rise to in cause (a), stating lying cause last.  PART II. OTH  | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (  DUE TO  mediate the under-  JER SIGNIFICANT CON   | (c) NDITIONS CC  | han years  | (c).]  | . C.J. Ne  | MINAL DISEASE  | CONDITION G  |                           | INTERV.<br>ONSE)<br>20                  | AL BETWEEN AND DEATH              |
| CAL CERTIFICATION     | Canditions, if all gave rise to in cause (a), stating lying cause last.  PART II. OTH  | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (  DUE TO  ny, which the under:  UER SIGNIFICANT CON  SUNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  | b) Do NDITIONS CC  | ONTRIBUTING TO   | DEATH BUT Y OCCURRET                           | C, J, Me   | MINAL DISEASE TO PORT I or Port  | CONDITION G  | IVEN IN PAR               | INTERV.<br>ONSE)<br>20                  | AL BETWEEN AND DEATH              |
| MEDICAL CERTIFICATION | PART 1. DEA  Canditians, if as gave rise to ir cause (a), stating lying cause last.  PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY  20c. TIME OF INJUR Haur a. m. p. m.  | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (  DUE TO  THE MINISTRUMENT CON  SUNDERLYING  CAUSE OF DEATH  MEDICAL EXAMINER)  Y Manth, Doy, Ye  | o) b) c) NDITIONS CO 20b. DESCR arr 20d. INJ While at wark             | ONTRIBUTING TO RIBE HOW INJUR  URY OCCURRED Not while of work                  | DEATH BUT Y OCCURRET                           | NOT RELATED TO THE TERM  O. (Enter nature of injury in   | MINAL DISEASE  To Port I or Port  Torrer, 20f. (City   | CONDITION GI   | VEN IN PAR                | RT 1(a) 19. V                           | VAS AUTOPS<br>ERFORMED?<br>S NO   |
| MEDICAL CERTIFICATION | PART 1. DEA  Canditians, if an gave rise to in cause (a), stating lying cause last.  PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY)  20c. TIME OF INJUR' Hour a. m. p. m.  21. I certify th alive an   | TH WAS CAUSED 8Y: IMMEDIATE CAUSE ( DUE TO ny, which mediate the under:  UER SIGNIFICANT CON  SUNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  Y Month, Doy, Ye  | o) b) c) NDITIONS CO 20b. DESCR arr 20d. INJ While at wark             | ONTRIBUTING TO RIBE HOW INJUR  JURY OCCURRED Of work  of work                  | DEATH BUT Y OCCURRED                           | NOT RELATED TO THETERA  D. (Enter nature of injury in tary, street, office bldg., etc.)  19 56, ta   | WINAL DISEASE  Port I or Port  (m., 20f. (City  Lt.)  M, from  | CONDITION G  | VEN IN PAR  (  ,that I lo | INTERVONSE)  RT 1(a) 19. y  YE  Caunty) | VAS AUTOPS ERFORMED? S NO (State  |
| MEDICAL CERTIFICATION | PART 1. DEA  Canditians, if any gave rise to in cause (a), stating lying cause last.  PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY  20c. TIME OF INJURY Hour o. m. p. m.  21. I certify th  | TH WAS CAUSED 8Y: IMMEDIATE CAUSE ( DUE TO ny, which mediate the under:  UER SIGNIFICANT CON  SUNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  Y Month, Doy, Ye  | o) b) c) NDITIONS CC 20b. DESCR 20d. INJ While at wark                 | ONTRIBUTING TO RIBE HOW INJUR  JURY OCCURRED Of work  of work                  | DEATH BUT Y OCCURRED                           | NOT RELATED TO THETERA  D. (Enter nature of injury in tary, street, office bldg., etc.)  19 56, ta   | WINAL DISEASE  Port I or Port  (m., 20f. (City  Lt.)  M, from  | CONDITION G  | VEN IN PAR  (  ,that I lo | INTERVONSE)  RT 1(a) 19. y  YE  Caunty) | VAS AUTOPS ERFORMED? S NO (State  |
| MEDICAL CERTIFICATION | PART 1. DEA  Canditians, if all gave rise to in cause (a), stating lying cause last.  PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY  20c. TIME OF INJUR' Haur o. m. p. m.  21. I certify th alive an  ACTUAL SIGNATURE  PHYSICIAN'S  | TH WAS CAUSED 8Y: IMMEDIATE CAUSE ( DUE TO ny, which mediate the under:  UER SIGNIFICANT CON  SUNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  Y Month, Doy, Ye  | a) b) c) NDITIONS CC  20b. DESCR While at wark e deceased 19           | DATRIBUTING TO  RIBE HOW INJUR  JURY OCCURRED  Of work  of fram.  Jury and the | DEATH BUT Y OCCURRED  20e. PL face             | NOT RELATED TO THETERA  D. (Enter nature of injury in tary, street, office bldg., etc.)  19 56, ta   | MINAL DISEASE  Port I or Port  Total  Approximation (City  Approximation | CONDITION GI   | VEN IN PAR  (  ,that I lo | INTERVONSE)  RT 1(a) 19. y  YE  Caunty) | VAS AUTOPS ERFORMED? S NO (State  |
| WEDICAL CERTIFICATION | PART 1. DEA  Canditians, if ar gave rise to ir cause (a), stating lying cause last.  PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY  20c. TIME OF INJUR' Haur a. m. p. m.  21. I certify th alive an  ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type)  BURIALL CREMATIVE  COMMENT OF THE COM | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (  DUE TO  The which and the under-  DUE TO  CAUSE OF DEATH MEDICAL EXAMINER)  Y Manth, Doy, Ye  The strength of the under-  The strengt | a) b) c) c) NDITIONS CC  20b. DESCR While at wark e deceased 19 47, M. | ONTRIBUTING TO  RIBE HOW INJUR  JURY OCCURRED  of work  of fram                | DEATH BUT  Y OCCURRED  20e. PLA fac  hat death | NOT RELATED TO THE TERM  O. (Enter nature of injury in the control of the control | MINAL DISEASE Port I or Port  m, 20f. (City fc.)  M, fram ADDRESS (St  | CONDITION GI   | (,that I lond an the      | INTERVONSE)  RT 1(a) 19. y  YE  Caunty) | VAS AUTOPS ERFORMED? S NO (State  |
| MEDICAL CERTIFICATION | PART 1. DEA  Canditians, if all gave rise to incause (a), stating lying cause last.  PART II. OTH  20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY  20c. TIME OF INJURHOUT a. m. p. m.  21. I certify the alive an   | TH WAS CAUSED 8Y: IMMEDIATE CAUSE (  DUE TO  The mediate the under-  DUE TO  (I)  A UNDERLYING II  MEDICAL EXAMINER)  Y Manth, Doy, Ye  19  at I attended the  The country of the country | a) b) c) c) NDITIONS CC  20b. DESCR While at wark e deceased 19 47, M. | DITRIBUTING TO  RIBE HOW INJUR  OCCURRED  Of wark  of wark  of wark  D. 40     | DEATH BUT  Y OCCURRED  20e. PLA fac  hat death | NOT RELATED TO THETERA  D. (Enter nature of injury in the late)  ACE OF INJURY (Hame, for tory, street, office bldg., etc., 1956, ta., accurred at., 3.1.  M.D.  R CREMATORY   | MINAL DISEASE Port I or Port  m, 20f. (City fc.)  M, fram ADDRESS (St  | condition Gill af item 18.)  or town)  the causes a reet, city ar tawn  ION (City, tawn, | (,that I lond an the      | Caunty)                                 | VAS AUTOPS ERFORMED? S NO (State  |



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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| 5 | 2    | 11 | 11) |
| 5 | file | 1  |     |
| 5 | 0    |    |     |

Page 4

may be retained by capital or attending physician. **5 FUNERAL DIRECTO**Another this certificate has been signed by the attending physicion ond campletely filled in by the fupage 3 should be detached for use as the burial-transit permit. Then please remove corbon popers. Poges 1 and 2 shauld the State Board of Health prior to burial, crematian, ar removal, ond in any event, within 72 haurs after death.

ADING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after degith.

TAL OR ATTER

| TO HOSPIT |   | TO FUNER | da S. appo |
|-----------|---|----------|------------|
| VR<br>1S  | A | 9/5      | 14         |

| 1, [          | PLACE OF DEATH   | comico  | MARYLAND                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  a. STATE b. CONTROL  b. CONTROL  b. CONTROL  contro |                |                  |                                 |                  |           |           |  |
|---------------|--|---|------------------------------|--|----------------|------------------|---------------------------------|------------------|-----------|-----------|--|
|               | b. CITY OR TOWN (IF  | autside carporate limits, write                             | c. LENGTH OF STAY IN 16      | c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)   |                |                  |                                 |                  |           |           |  |
|               | RURAL and give ne  | antico  | 3 Yrs.                       | X Quantico   |                |                  |                                 |                  |           |           |  |
|               | d. NAME OF HOSPITA   | AL (If not in haspital, give stree                          |                              | d. STREET A  | DDRESS         |                  |                                 |                  | e. IS RE  | SIDENCE   |  |
|               | or institution<br>Cher                                     | crywalk Rd.,  |                              | C:   | herryv         | valk Rd          | • ,                             |                  |           | NO 🔀      |  |
| 3.            | NAME OF<br>DECEASED  | First   | Middle                       | Las  | t              | 4. DATE<br>OF    | Man                             | th               | Day       | Year      |  |
|               | (Type ar print)  | CORA  | TAYLOR                       | GILL   | IS             | DEATH            |                                 | 4                | 20        | 1961      |  |
| 5. 9          | SEX  | 6. COLOR OR RACE 7. MA                                      | RRIED NEVER MARRIED          | 8. DATE OF BIRTI   | Н              | 9.               | AGE (In years<br>last birthday) | IF UNDER 1 YE    |           | T         |  |
| - 4           | Female   | White WIDON   | WED DIVORCED                 | 8-29-18  | 71             |                  | 89 угз.                         | Manths Day       | s Haurs   | Min.      |  |
| 10a           | . USUAL OCCUPATIO  | N (Give kind of work dane 10)<br>ing life, even if retired) | b. KIND OF BUSINESS OR INDU  | STRY 11. BIRTHPL   | ACE (State o   | ar fareign cour  | ntry)                           | 12. CITIZEN      | OF WHAT   | COUNTRY?  |  |
|               | House V  | Vife  | Own Home                     | Mar  | yland          |                  |                                 | U.S              | . A.      |           |  |
| 13.           | FATHER'S NAME  |   |                              | 14. MOTHER'S   | MAIDEN N.      | AME              |                                 |                  |           |           |  |
|               | George Wa  | ashington Tayl  | or                           | Marg   | aret A         | lnn Ing          | ersoll                          |                  |           |           |  |
|               |  | IN U. S. ARMED FORCES?                                      | 6. SOCIAL SECURITY NO. 17.   | NFORMANT   |                | 1156             | Add                             | ress             |           |           |  |
| (Te           | no, or unknown)  | If yes, give war or dates of service)                       | Mr                           | s. Mario   | n C. E         | Bailey,          | Same                            |                  |           |           |  |
|               | IB. CAUSE OF DEA   | TH [Enter anly ane cause per                                | line far (a), (b), and (c).] |  | ,              |                  |                                 | [1]              | NTERVAL B | ETWEEN    |  |
|               | PART I. DEAT   | TH WAS CAUSED BY:   | Colonina                     | le le  | Hes            | + 12             | nani                            | C                | NSET ANI  | DEATH     |  |
|               | 4200   | IMMEDIATE CAUSE (a)   | Co co co                     |  | IV             | ~ //             |                                 |                  | 7         |           |  |
|               | Canditians, if ar  |   |                              |  |                |                  |                                 |                  |           |           |  |
|               | gave rise to in  | n mediate   |                              | -  |                |                  |                                 |                  |           |           |  |
|               | cause (a), stating t                                       | he under- DUE TO  |                              |  |                |                  |                                 |                  |           |           |  |
| z             |  | FR SIGNIFICANT CONDITIONS                                   | S CONTRIBUTING TO DEATH BU   | NOT BELATED TO   | THE TERMIN     | LAI DICEACE C    | CANDITION CIV                   | (ENLINI DADT 1/a | VIO WAS   | ALITOPSY  |  |
| 5             | I ANT II. OTH  | EK SIGNIFICANT CONDITIONS                                   | CONTRIBUTING TO DEATH BU     | NOT KECKTED TO   | THETEKMIN      | AME DISEASE C    | ONDITION ON                     | TEN IN PART 1(0  | PERF      | ORMED?    |  |
| 2             | 22 4 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2                     |   | voras a                      | Jection  |                |                  | ( ) 10 1                        |                  | YES [     | NO [      |  |
| CERTIFICATION | 20g. ACCIDENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY) | S UNDERLYING   206. DI CAUSE OF DEATH MEDICAL EXAMINER)     | ESCRIBE HOW INJURY OCCURRI   | D. (Enter nature a   | it injury in P | art I ar Part II | or item 18.)                    |                  |           |           |  |
| MEDICAL       | 20c. TIME OF INJURY  |   | L.                           | ACE OF INJURY  |                |                  | r tawn)                         | (Caun            | ty)       | (State)   |  |
| MED           | Haur a.m.  | 19 Whi  | le Not while ark at wark     | ctary, street, affice  | e blag., etc.; | 1                |                                 |                  |           |           |  |
|               |  |   | nded the deceosed from.      | 21/1   | 10.4           | 61. to           | dot                             | 19               | that (I)  | (we) last |  |
|               |  | 4111  | - /1                         | / -  |                | •                |                                 |                  |           |           |  |
| -             | sow the deceas   | ed dive on  | b 17 91 , and that           | death occurred   | OWIA           | M, fram in       | ie couses on                    | a on the ac      |           | 2b. DATE  |  |
|               | 250.0.0.0.74.0.0.2   | Ent n. I  | armon                        | M.D. ATTENDIN  | G ME DIR       | D.<br>RECTOR     | STAFF PHYS.                     | 4-               | 20-19     | SIGNED    |  |
|               | 22c. PHYSICIAN'S   |   |                              | 22d. ADDRI   |                |                  |                                 |                  |           |           |  |
| -1            | NAME (Type)  | Ernest M. Lar   | more                         | Grav   | e St.          | , Delma          | r, Dela                         | ware             |           |           |  |
| 230           | BURIAL, CREMATIO   | N, 23b. DATE THEREOF  | 23c. NAME OF CEMETERY (      | R CREMATORY  |                | 23d. LOCATIC     | N (City, tawn,                  | ar caunty)       | (Sto      | ote)      |  |
|               | REMOVAL (Specify)  | 4-22-1961   | Siloam Cemete                | erv  |                | Siloa            | m. Mary                         | land             |           | 17-13     |  |
| 24.           | FUNERAL DIRECTOR'S   |   | ADDRESS                      | - 1  | 250. REC'D     | BY REGISTRA      | - 4                             | STRAR'S SIGNA    | TURE      |           |  |
|               | Hill & Joh   | nson Co. Salis  | bury, Maryland               |  | DATEDD         | 25'61            | LA LA LO                        | Lug S. Kra       |           |           |  |
|               | 11-11 0.0011   | TIONI OOF DOLLAR  | ,                            |  | RED            | 2001             | 1 Cui                           | A. MA            | AA/48     |           |  |

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### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4940

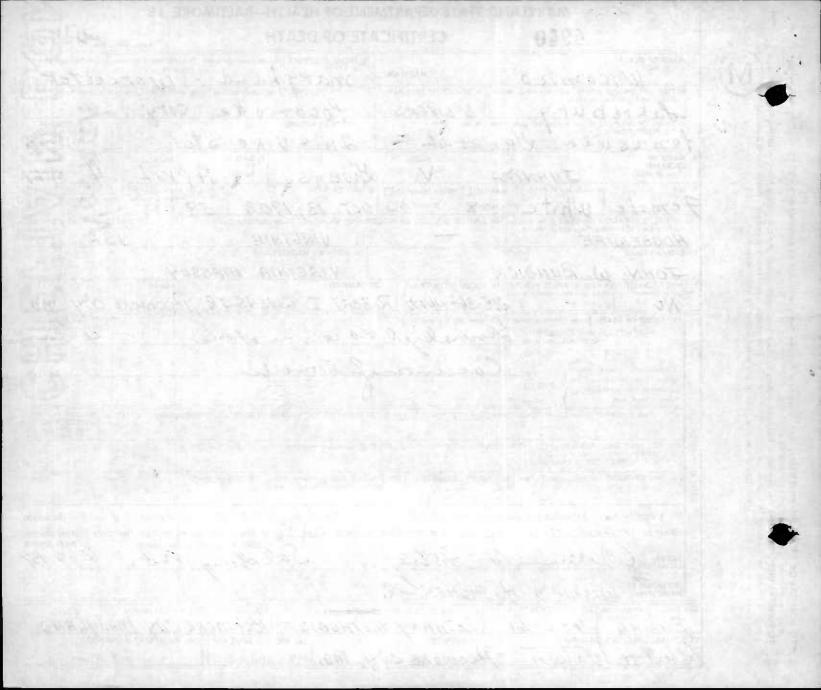
### **CERTIFICATE OF DEATH**

Reg. Dist. No. (14928

| 1  | PLACE OF DEATH O. COUNTY   |               | 2. USUAL RESIDEN<br>o. STATE | CE (Where deceased    | lived. If institution | 1: Residence be | fore admissio | on)     |
|----|--|---------------|------------------------------|-----------------------|-----------------------|-----------------|---------------|---------|
| L  | WICOMICO   | MARYLAND      | mar                          | 4 Lang                | L. //                 | LOTCO           | 25/01         |         |
|    | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)   | OF STAY IN 16 | c. CITY OR TOW               | (If outside corpo     | rote limits, write RU | RAL and give n  | earest town)  | 0.00    |
|    | Sahisbuty 6 W.   | EEKS          | Poco                         | mok                   | e C17                 | 4               | タン            | Par     |
| 1  | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |               | d. STREET ADD                | RESS                  | - 1-                  |                 | e. IS RESID   |         |
|    | Jeninsula Menera   | _             | 2 Nd 4                       | VINE                  | STs.                  |                 | YES 🗌         |         |
| 3  | 3. NAME OF First • Processed   | Middle        | , , Last                     | 4. DATE<br>OF         | Manth                 | 1. [            | Day, Ye       | or      |
|    | (Type or print) JUANITA  | V.            | Vivens                       | DEATH                 | APYI                  | 1               | 4, 15         | 61      |
| 5  | 6. COLOR OR RACE 7. MARRIED NEVEL  | MARRIED       | B. DATE OF BIRTH             |                       | 1 4 5 4 1 1           | F UNDER 1 YEA   | 1             |         |
| -  | Female White WIDOWED &   | DIVORCED 🗌    | OCT. 13.                     | 1902                  | Je yrs.               | Months Doys     | Hours         | Min.    |
| Ĩ  | 0o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   | INESS OR INDU | STRY 11. BIRTHPLACE          | (State or foreign co  | ountry)               | 12. CITIZEN     | OF WHAT CO    | UNTRY?  |
|    | HOUSEWIFE  |               | VIR                          | SINIA                 |                       | 115             | A             |         |
| 1  | 3. FATHER'S NAME   | LUTET ILL     | 14. MOTHER'S MA              | IDEN NAME             |                       |                 |               |         |
|    | JOHN W. BUNDICK  |               | VIRG                         | INIA M                | ASSEY                 |                 |               |         |
|    | S. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECU  | RITY NO. I    | NFORMANT'                    | ,                     | Addre                 | /55             |               |         |
|    | (If yes, give war or dates of service) 215-36-1-   | 442 Re        | BERT I.                      | GIVENS -              | TR. Poco              | MOKE L          | 114.1         | no.     |
|    | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b),  | ond (c).]     |                              |                       |                       | IN              | TERVAL BET    | WEEN    |
|    | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Zoner   | lind          | Carein                       | our ato:              | ain                   |                 |               | mont    |
|    | DUE TO   |               |                              |                       |                       |                 |               | 711     |
|    | Conditions, if any, which ) (as Ca   | 178-          | 2 Ston                       | ~GCI.                 |                       | COLT 7          |               |         |
|    | gove rise to immediate DUE TO  |               |                              |                       |                       |                 |               |         |
|    | cause (o), stating the <u>under-</u> lying cause lost.   |               | 0                            |                       |                       |                 |               |         |
| 1  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING   | TO DEATH BUT  | NOT RELATED TO TH            | E TERMINAL DISEASI    | CONDITION GIVE        | N IN PART 1(a)  | 19. WAS AL    | JTOPSY  |
|    | 3  |               |                              |                       |                       |                 | YES T         |         |
|    | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  20g. ACCIDENT WAS UNDERLYING  20g. ACCIDENT WAS UNDERLYING  20g. ACCIDENT WAS UNDERLYING  (IF EITHER, NOTIFY MEDICAL EXAMINER) | JURY OCCURRE  | D. (Enter nature of in       | ury in Port I ar Part | II of item 18.)       |                 |               |         |
| 1  | OR CONTRIBUTING (IF EITHER, NOTIFY MEDICAL EXAMINER)   |               |                              |                       |                       |                 |               |         |
| 1  | 20c. TIME OF INJURY Manth, Day, Year 20d, INJURY OCCUP   | RED 20e. PL   | ACE OF INJURY (Ham           | e, form, 20f. (City   | or tawn)              | (County         | ν)            | (Stote) |
| 1  | 20c. TIME OF INJURY Manth, Day, Year While Not whi of work of work of work   | le foo        | ctory, street, office blo    | lg., etc.)            |                       | (/              |               | (/      |
| 1  |  | 100-          | - / 0                        | 2020                  | // //                 |                 |               |         |
| 1  | 11. 11   |               | , 19 <u>60</u> , t           | 1 L Z A               | 4, 19 6h              |                 |               |         |
| П  | alive an 1100 7, 1961, an  | d that death  | accurred at                  |                       |                       |                 |               |         |
|    | ACTUAL (1) 480.0 (1. 2)  | 01            |                              | ADDRESS (SI           | reet, city or town, s | late)           | U -C          | SIGNED  |
|    | SIGNATURE CONTRACTOR (F. 77)   | wit.          | M.D                          | aush                  | uy th                 | $\alpha$ .      | ~-X           | 0/      |
|    | PHYSICIAN'S WILLIAM H. FISHE   | R. JR.        |                              |                       |                       |                 |               |         |
| 2  | 2a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME   | OF CEMETERY & | E CONTRACT                   | 22d_LOCA1             | ION (City, tawn, or   | county)         | (State)       |         |
|    | BURIAL 4-6-61 BETH   | IANU N        | PETHODIS                     | Y Bear                | MOKE MY               | y MAK           | WLAN          | (1)     |
| 12 | 3. FUNERAL DIRECTOR'S SIGNATURE ADDRES   | 5             |                              | . REC'D BY REGIST     | RAR 24b. REGIST       | RAR'S SIGNAT    | URE           | <u></u> |
| 1  | West H. Walson Pocome  | NE CIL        | W. Mil. DA                   |                       |                       | Inthun 8. 9     | Kanua         |         |
| A  | 100000   | -16-          | 111.01                       | BCD. 1                | 70                    | and the         | A Parkethon   |         |

ING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter de After this certificate has been signed by the attending physician and campletely filled in by the funded for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should the registrar prior to buriol, crematian, or remaval, and in any event within 72 haurs after death TO FUNERAL DIRECTON. After this certificate has been signed by page 3 shauld be detoched for use as the burial-transit permit.

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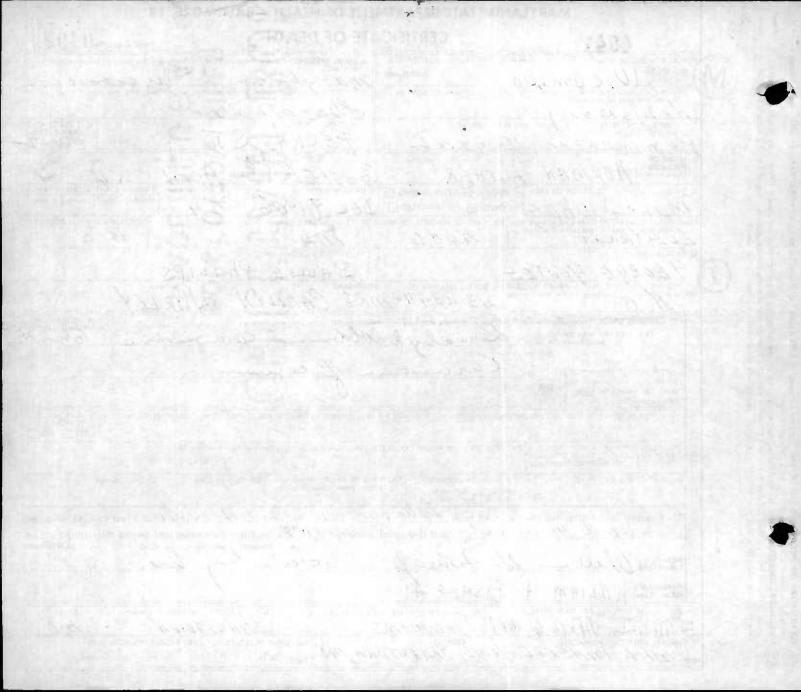


| MARYLAND STATE DEPARTMENT OF HE | LTH-BALTIMORE, 18 |
|---------------------------------|-------------------|
|---------------------------------|-------------------|

|         | 4941 Items 4 & 21 Film 4-201   | OF DEATH Reg. Dist. No. () 4929  |
|---------|--|--|
|         |  | TAL RESIDENCE (Where deceased lived. If institution: Residence before admission) TATE  b. COUNTY   |
| 1       | RURAL and give nearest tawn)   | ITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)   |
| 7       | d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION  d. S   | STREET ADDRESS  6. IS RESIDENCE ON A FARM? YES NO [Z]  |
|         | NAME OF DECEASED (Type or print) HORMAN LUTHER   | Last 4. DATE Manth Day Year OF DEATH AD CIA 3. 14 196  |
| S. :    | S. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   8. DATE (   | OF BIRTH  9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR  Down birthday)  4 yrs.  Manths Days Hours Min.  |
| 100     | 10a. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR INDUSTRY 11.  | BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY   |
| 13.     | 13. FATHER'S NAME 14. MG   | OTHER'S MAIDEN NAME<br>PALLIE PHILLIPS   |
|         | (Yes, no. or ynthrown) (If yes, give wor or dates of service) 2/3-0347/2 MRS   | CAROLYN HURLEY   |
|         | 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  | Command Carculan otris Onset and Death   |
|         | Canditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.  DUE TO  (b)  Carculor  (b)  Carculor  (c)   | of cecum   |
| CATION  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REL  | ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS' PERFORMED?  YES \( \subseteq \text{NO} \subseteq \text{VES} \subseteq \text{NO} \text{VES} \left\text{VES} \subseteq \text{NO} \text{VES} \left\text{NO} \text{VES} \subseteq \text{NO} \te |
| CERTIFI | 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTION CONTRIBU | nature of injury in Part I or Port II of item 18.)   |
| MEDICAL | 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED Haur a. m. While Not while at work at work   | NJURY (Hame, farm, 20f. (City ar tawn) (Caunty) (State, affice bldg., etc.)  |
|         | 24 4 24  | 1960, ta affect 1 3, 196 (that I last saw the decease red at 117. M, fram the causes and an the date stated above  |
|         | SIGNATURE William 18. Fisher & M.D.  | Salishy hu, DATE SIGNE   |
|         | PHYSICIAN'S WILLIAM H. FISHER FR   |  |
|         | PRINCIPLE APRIL 6, 1961 FIREMENS   | STORY 22d LOCATION (City, town, or county) (Stote)   |
| 23.     | S. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  | 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  OATE APR 1 0 '61  Outly 2. Known   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after deap. Page 4 Section 24 hours after this certificate has been signed by the attending physician and campletely filled in by the fundamental process. Page 3 should be described for use as the hurral-transit permit. Then places remove carbon pages. Page 3 and 3 should be filled with may be retained by it spital ar attending physician.

O FUNERAL DIRECTON, After this certificate has been signed by the attending physician and campletely filled in by the fune page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be the registrar priar to burial, crematian, ar removal, and in any event within 72 haurs after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

25 F filled plet papers. COM puo carbon physician hours remove 72 attending pleose

permit. been signed physician hos certificate the detached TO FUNERAL DIRECTOR poge 3 should be deta

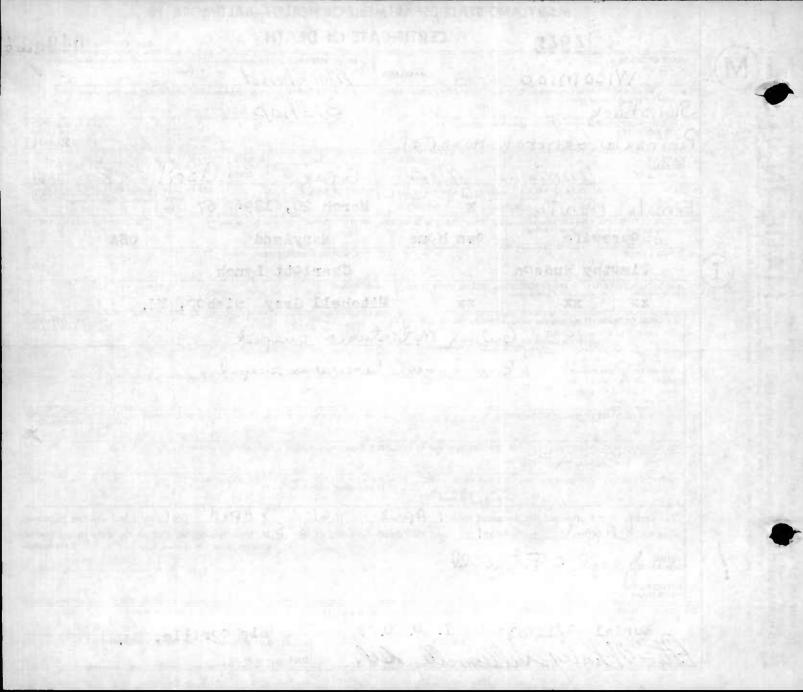
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burial

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registror

VS A15 (4)



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| 943 | CERTIFICATE | OF | DEATH |
|-----|-------------|----|-------|
|     |             |    |       |

|   | 494  | ઇ          | CERT                     | IFIC/     | AIE OF                 | DEAL                           | Н                            |                  | Reg. Dist.               | No.[] 4      | 034                        |
|---|--|------------|--------------------------|-----------|------------------------|--------------------------------|------------------------------|------------------|--------------------------|--------------|----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY  | lcomico  |            | MAI                      | RYLAND    | 2. USUAL R<br>o. STATE | ESIDENCE (V                    | Where deceased live          | b. COUNTY .      | Residence t              | pefore admir | ision)                     |
| b. CITY OR TOWN RURAL and give  |  | its, write | c. LENGTH OF STA         |           | c. CITY (              | OR TOWN (I                     | f outside corporate<br>erton | limits, write RU | RAL and give             | nearest law  | m)<br>X                    |
| OR INSTITUTION  | ITAL (If not in hospitol, solid).                          |            | address)                 |           | d. STREE               | T ADDRESS                      |                              |                  |                          | ON           | SIDENCE<br>A FARM?<br>NO X |
| 3. NAME OF<br>DECEASED<br>(Type or print)                                   | Verina   | rst        | Midd                     |           | Hacke                  | lost<br>tt                     | 4. DATE<br>OF<br>DEATH       | April            | 2                        | Bay          | Yeor<br>19 196             |
| 5. SEX<br>Female  | 6. COLOR OR RACE White                                     | 7. MARI    |                          |           | 8. DATE OF 8           | 29 <b>.</b>                    | #1868                        |                  | F UNDER 1 Y<br>Months Do |              |                            |
| 10a. USUAL OCCUPAT<br>during most of we<br>HOUS                             | ION (Give kind of work orking life, even if retired SEWIIE | done 10b.  | KIND OF BUSINESS<br>Home | OR INDU   | STRY 11, BIRT          | HPLACE (SIO                    |                              | у)               |                          | S. A         | T COUNTRY                  |
| 13. FATHER'S NAME   |  |            |                          |           | 14. MOTH               | R'S MAIDEN                     |                              |                  | 1 0 4                    | V            |                            |
| Call Call Sec   | Thomas   | Rasi       | n                        |           |                        | Un                             | known                        |                  |                          |              |                            |
| IS. WAS DECEASED EV   | ER IN U. S. ARMED FOI                                      |            | None                     |           | nformant<br>anitar     | ium 1                          | Records                      | Sal:             | isbur                    | y, Mo        |                            |
| Canditions, if gove rise to couse (a), stating lying couse last  PART II. O | the under-   | :)         | CONTRIBUTING TO D        | DEATH BUT |                        |                                | MINAL DISEASE CO             |                  | N IN PART 1(             | PERF         | AUTOPSY<br>ORMED?          |
| 20a. ACCIDENT W   | VAS UNDERLYING [] IG [] CAUSE OF DEATH Y MEDICAL EXAMINER) | 20b. DES   | CRIBE HOW INJURY         | OCCURRE   | D. (Enter natu         | re of injury i                 | n Part I or Port II o        | f item 1B.)      |                          | 165          | , 140                      |
| 20c. TIME OF INJU<br>Haur o. m.<br>p. m.                                    | 10   | While      | NJURY OCCURRED Nat while | 20e. Pl   | ACE OF INJUI           | (Y (Home, fo<br>ffice bldg., o | orm. 20f. (City or telc.)    | own)             | (Cau                     | nty)         | (State)                    |
| 21. I certify in alive on  ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)         | that I aftended the<br>4 - 21<br>Plugs C<br>Philip A       |            | sley M.                  | D,        | M.D1                   | oil2:1                         |                              | e causes an      | d on the                 | date stat    | ATE SIGNE                  |
| 220. BURIAL, CREMATI  | 226. DATE THERE  | _          | Still                    |           |                        |                                | Still                        |                  | Md.                      | (Sto         | ite)                       |
| 23. FUNERAL DIRECTO   | R'S SIGNATURE  | - de       | ADDRESS<br>Still         | Pone      | d. Md.                 |                                | C'D BY REGISTRAR             |                  | - 11                     |              |                            |

|                 | TE OF DEATH  | CERTIFICA                  |  |
|-----------------|--|----------------------------|--|
|                 |  |                            | on hope the  |
|                 |  | arany L                    | Selabury   |
| No. of the last | AND THE STATE OF T |                            | metration of handres   |
| 23, 139         | Erga Han Justical  |                            | an May A American  |
|                 | Nov. 20, 20186 98.   |                            | and the state of and   |
| A .E .D         | hard Lyes  |                            | Director of the same of the same of  |
|                 | in second control of   |                            | i nell : amout Strome : Hare is  |
| A CHARLETTE     | nicaetm Hemoria  |                            | A THE RESERVE AND A PROPERTY OF THE PARTY OF |
|                 |  |                            |  |
| 9,              |  |                            |  |
|                 |  |                            |  |
|                 |  |                            |  |
|                 |  | the action to              |  |
|                 | . Jo sacy leta St.   |                            | SOT A COLUMN CONTRACT  |
|                 | hear first vents for   | A CONTRACTOR OF SECURITION | Street Land Control of the Control o |
|                 | el de la montra e sur del<br>El destrucción de la finale   |                            | Magazina arthronia   |

MARYLAND STATE

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MARYLAND STATE DEPARTMENT OF HEALTH

ETH ET, BALTIMORE 1, MARYLAND ()4952

| /ISION | OF STATIST | TICAL RESEARCH | AND RE | CORDS, 3 | 01 W. | PRESTON | STREE |
|--------|------------|----------------|--------|----------|-------|---------|-------|
|        | 4944       | 4              | CERTIF | ICATE    | OF I  | DEATH   |       |

|                  | PLACE OF DEATH                            |                                  |               |              |                |                      | ESIDE   | NCE (Whare       |                |          |          | Residen  | ce before e   | dmissio |
|------------------|---|----------------------------------|---------------|--------------|----------------|----------------------|---------|------------------|----------------|----------|----------|----------|---------------|---------|
|                  |   | icomico                          |               | IV           | TARYLAND       | e. STATE             | Mary    | land             | D.             | COUN     |          | orce     | ster          |         |
|                  |   | f outside corporete limi         | ts,           | c. LENGTH C  | OF STAY IN 16  | c. CITY O            | WOT S   | (If outside co   | rporata limit  | s, write | RURAL e  | nd give  | neerest tow   | rn)     |
|                  | Salisbur                                  | give nearest town)               |               | 69           | days           | W                    | hale    | yville           |                |          |          |          |               |         |
|                  |   | TAL OR INSTITUTION               | if not in hos |              | 0              | d. STREET            |         |                  |                | 1        | 71       |          | e. IS RI      |         |
| 1                |   | Head State                       | Hosp          | ital         |                |                      |         |                  |                | 7        | 3)       | X        | YES 🗌         | A FARM  |
| 3.               | NAME OF<br>DECEASED                       | First                            |               | Mid          | ldle           | Last                 |         | 4. DATE          |                | Month    |          | Dey      | Yeer          | r       |
|                  | (Type or print)                           | Laura                            | l.            | I            |                | Hamblin              | 1       | DEAT             | TH A           | pri      | 1 26     |          | 19            | 61      |
| 5.               | SEX                                       | 6. COLOR OR RACE                 | 7. MARRIE     | D NEVER M    | ARRIED         | . DATE OF BIRT       | Н       |                  | 9. AGE (In     |          |          |          | IF UNDER      |         |
|                  | Female                                    | White                            | WIDOWE        | D DIV        | ORCED          | May 30               | ). ]    | 1876             | 84             | yrs.     | Months   | Days     | Hours         | Min.    |
|                  |   | ION (Give kind of work           |               | ND OF BUSINE | SS OR INDUST   | RY 11. BIRTHPL       | ACE (Co | ounty & State,   | or foreign co  | ountry)  | 12. C    | ITIZEN C | F WHAT        | OUNTR   |
| ao               | Housewif                                  | rking lifa, even if retire       |               | n Home       |                | Mary                 | 737     | nđ               |                |          |          | USA      |               |         |
| 13.              | FATHER'S NAME                             |                                  |               |              |                | 14. MOTHER'S         |         |                  |                |          |          | ODA      |               |         |
|                  | Lemuel                                    | Davis                            |               |              |                | (1                   | NKN     | (NWO)            |                |          |          |          |               |         |
|                  | WAS DECEASED EV                           | ER IN U.S. ARMED FOR             |               | SOCIAL SECUI | RITY NO.   17. | INFORMANT            | 21001   | 1111/            | A              | ddress   |          |          |               |         |
| (Ye              | s, no, or unkown)   (I                    | fyesgive wer or detes of s<br>XX | ervice)       | xxx          | Mr             | T.Out                |         | Campb            | 677 9          | I For    | h tete f | 110      | Da            | 7       |
| All Printers and |   | EATH [Enter only one             | cause per l   |              |                | 5. 110U1             | . 80    | Jampu            | CTT K          | SET      | O y v 1  | TIN      | De TERVAL BET | WEEN    |
|                  |   | H WAS CAUSED BY:                 |               |              |                | 2 11                 |         | 1 1 1 1 1        |                |          |          | 10       | SET AND       |         |
|                  | 1 1                                       | IMMEDIATE CAUSE (e)              | ле            | current      | cerebr         | al thron             | ibos    | is               |                |          |          | -        | Year          | 3       |
| 7                | 22  | DUE TO                           | A             |              |                |                      |         |                  |                |          |          |          | 35            |         |
|                  | Conditions, if eny<br>gave rise to immedi | (-)                              | Ar            | ceriosc      | terosis        | , genera             | Liz     | ed               |                |          |          |          | Year          | 3       |
|                  | (e), stating tha u                        | DI DI I TO                       |               |              |                |                      |         |                  |                |          |          |          |               |         |
|                  | ceusa lest.                               | ) (c)                            |               |              |                |                      |         |                  |                |          |          |          |               |         |
| NO               | PART II, OTHER                            | SIGNIFICANT CONDI                | TIONS CON     | TRIBUTING TO | DEATH BUT NO   | OT RELATED TO        | THE TER | MINAL DISEAS     | E CONDITIO     | ON GIV   | EN IN PA | RT 1(a)  | 19. WAS A     | RMED?   |
| CERTIFICATION    |   |                                  |               |              |                |                      |         |                  |                |          |          |          | YES           | NO [    |
| TIL              |   | AS UNDERLYING THE                | 2Db. DES      | CRIBE HOW IN | JURY OCCURE    | ). (Enter neture o   | finjury | in Pert I or Per | t II of item 1 | B.)      |          |          |               |         |
| CER              |   | MEDICAL EXAMINER)                |               |              |                |                      |         |                  |                |          |          |          |               |         |
| CAL              | 20c. TIME OF INJU                         | IRY Month, Dey, Ye               |               | INJURY OCCUI |                | ACE OF INJURY        |         |                  | lity or town)  |          | (C       | ounty)   |               | (Stete) |
| MEDICAL          | Hour e.m.                                 | 19                               | While et wor  |              |                | tory, street, office | blag.,  | 916.)            |                |          |          |          |               |         |
| <                |   | hat (I) (this hospi              |               |              | h              | Tahma                | 7775    | 16967            | 0 1-           | T        | 26 1     | 61       | that (1) (    | (wa) I  |
|                  | 21. I certify I                           | nai (i) (iiiis nospi             | nril !        | 26 10 6      | and the        | death occur          | ad at   | W ***            | om the co      | Pite.    | and co   | the d    | ate state     | d abou  |
|                  | 22a. SIGNATURE                            | sed alive on                     | Mark State A  | 0 0          | L., and tha    | dealli occul         | eu ai   |                  | 7511 THO CE    | 34303    | and on   | 1110 0   |               | DATE    |
|                  | 228. SIGNATURE                            | 40                               | hul           | ul           |                | ATTENDIN             | IG      | MED.<br>DIRECTOR | STAFF          |          |          |          | 4/20          | SIGN    |
|                  | 22c. PHYSICIAN'S                          |                                  |               |              |                | 22d. ADI             |         |                  |                |          |          |          |               |         |
|                  | NAME (Type)                               | L. V. Ma                         | ldve,         | M. D.        |                | Deer                 | S       | Head Ho          | spita          | 1; 5     | Balis    | bury     | , Md.         |         |
| 23               | BURIAL, CREMATI                           | ON, 236. DATE THE                | REOF          | 23c. NAME    | OF CEMETERY    | OR CREMATOR          |         |                  | CATION (       |          |          | -        |               | tate)   |
|                  | Burial                                    | 4/29/6                           | 51            | Г            | Pale           |                      |         | Wh               | alevu          | 477      |          | 20.2     |               |         |
|                  |   | 1/5/                             | f also        | 1/1          | a L            |                      |         |                  |                |          | -        | ALC:     |               |         |

Dale

REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE

TO HOSPITAL ON TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 death. Page 4 may retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in E.

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E. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in E.

E. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in E.

E. De filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after the certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after the certificate has been signed by the attending the certificate with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after the certificate has been signed by the attending the certificate has been signed by the

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TO HOSPITAL OR A MUDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs after dg. "th. Page 4 may be relatived by the categories of the physician.

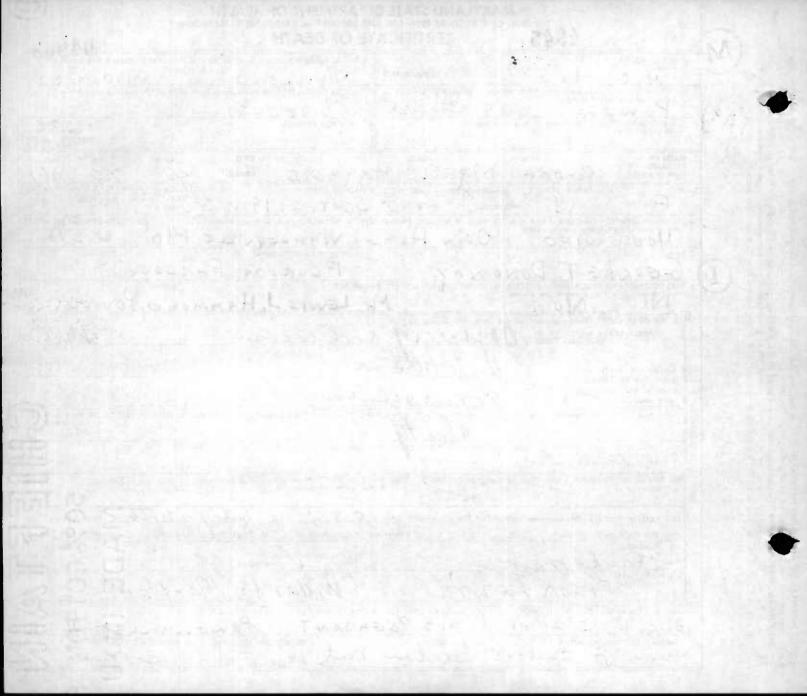
TO FUNERAL DIRECT. After this certificate has been signed by the attending physician and completely filled in by the 15 mill directar, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filled with the Stote Board of Health prior to burial, cremation, ar remaval, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STAT

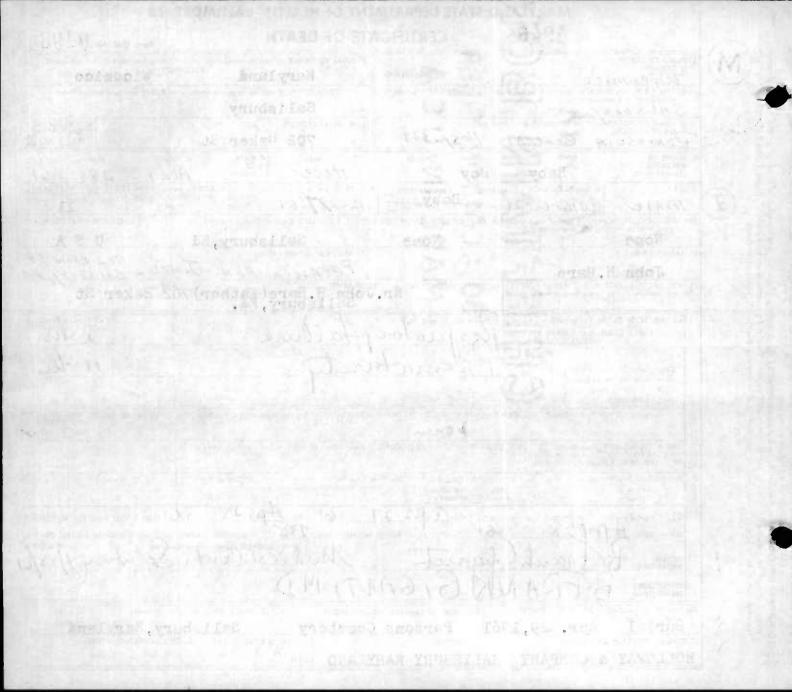
| ISTICAL RESEARCE | H AND | RECORDS | - BALTIMOR | E 1, | MARYLAND |
|------------------|-------|---------|------------|------|----------|
| CEDTIEIC         | ATE   | OF      | EATH       |      |          |

| 2349   | CERTIFICA                                       | IE OF DEATH  | Ω   | 4035                                  |
|--|---|--|---|---------------------------------------|
| o. COUNTY  | MARYLAND  | MARVLAND   | COUNTY WICOM  | 1100                                  |
| b. CITY OR TOWN (If outside corporate limits, RURAL and give nearest town)                             | 20000   | c. CITY OR TOWN (If outside corporate limit  | s, write RURAL and give neares                            | st town)                              |
| d. NAME OF HOSPITAL (If not in hospital, giv<br>OR INSTITUTION   |   | d. STREET ADDRESS  |   | IS RESIDENCE<br>ON A FARM?<br>(ES NO  |
| NAME OF DECEASED (Type or print)   | MARTLE H  | Last 4. DATE OF DEATH  | Month Day   | Year<br>196/                          |
|  | 7. MARRIED NEVER MARRIED DIVORCED DIVORCED      | SGPT, 21,1910 9. AGE lost b  | (In years   IF UNDER 1 YEAR IF Irthday)   Months Days   H | UNDER 24 HRS<br>Hours Min.            |
| during most of working life, even if retired)  | OVA HOM   |  | MD 12. CITIZEN OF W                                       | SA,                                   |
| GEURGE T. DO   | NOWAY   |  | RLOW  |                                       |
| S. WAS DECEASED EVER IN U. S. ARMED FORC   |   | LEWIS J. HAMM  | OND, POVIS  | LLYILL                                |
| 18. CAUSE OF DEATH [Enter only one coupert in DEATH WAS CAUSED BY:                                     | Oprywary  | declescon  |   | AL BETWEEN                            |
| Conditions, if ony, which gove rise to immediate couse (o), stoting the <u>under-lying couse lost.</u> | Aughertuckan                                    | irris  |   |                                       |
|  | Obesites  | T NOT RELATED TO THE TERMINAL DISEASE CONDI<br>A   | Y   | WAS AUTOPSY<br>PERFORMED?<br>'ES NO [ |
| OR CONTRIBUTING CAUSE OF DEATH   | Ob. DESCRIBE HOW INJURY OF CURRE                | ED. (Enter nature of injury in Part I or Part II of ite  | m 1B.)  |                                       |
| 20c. TIME OF INJURY Month, Doy, Year<br>Hour o. m.<br>p. m.  | 20d. INJURY OCCURRED 20e. PL fo ot work at work | ACE OF INJURY (Home, form, ctory, street, office-bidg., etc.)  | ) (County)  | (Stote                                |
| 21. I certify that (I) (this hospital) saw the deceased alive an                                       |   | death accurred atM, from the ca  | //  | (I) (we) las                          |
| French Lan   | rw  | M.D. ATTENDING MED. STAFF  |   | 22b. DATE<br>SIGNED                   |
| 22c. PHYSICIAN'S<br>NAME (Type) Frank F  | e-WIS   | Willards Ma  | aryland.  | ,                                     |
| 3a. BURIAL, CREMATION, 23b. DATE THEREOF   | 1 NIT PLO                                       | FASANT POWE  | UL VILLE (RF  | (Stote)<br>D) MI                      |
| 4. FUNERAL DIRECTOR'S SIGNATURE Burb   | Le Derlin                                       | 250. REC'D BY REGISTRAR CONTRACT CONTRA | 25b. REGISTRAR'S SIGNATURE                                |                                       |



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4946 CERTIFICATE OF DEATH Reg. Dist. No. () 4934

| 1. PLACE OF DEATH a. COUNTY                             | ico  | MARYLAND                          | 2. USUAL RESIDENCE (Vo. STATE Mary |                         | COLINITY                         | once before admission)                       |  |  |  |
|---|--|-----------------------------------|------------------------------------|-------------------------|----------------------------------|--|--|--|--|
|   | (If autside carporate limits, write nearest tawn)  | c. LENGTH OF STAY IN 1b           |                                    | f autside carporate li  | mits, write RURAL and            | give nearest tawn)                           |  |  |  |
| d. NAME OF HOSP<br>OR INSTITUTION<br>PENINSU            |  | Hospital                          | d. STREET ADDRESS                  | Baker St                | ,                                | e. IS RESIDENCE<br>ON A FARM?<br>YES NO      |  |  |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)               | Baby   | Boy Middle                        | HARE                               | 4. DATE<br>OF<br>DEATH  | April                            | Day Year<br>28 1961                          |  |  |  |
| 5. SEX<br>MAle  | 1.4.1  | RRIED NEVER MARRIED NED NED NECED | 8. DATE OF BIRTH 4-287-61          | 9. AG                   | t birthday) yrs.  IF UNDE        | Days Hours Min.                              |  |  |  |
| None  | ION (Give kind of work dane 10) Irking life, even if retired)  | None                              |                                    | ite or fareign country) |                                  | U S A  |  |  |  |
| 13. FATHER'S NAME  John                                 | H. Hare  |                                   | PATRICI                            | NAME                    | Todas                            | 702 BAKER ST<br>SALISBURY, MC                |  |  |  |
| 15. WAS DECEASED EV<br>(Yes, no, or unknown)            | (If yes, give war or dates of service)   |                                   | John H. Har<br>Salisbur            | e (Father               | ·)702 Bak                        |  |  |  |  |
|   | 18. CAUSE OF DEATH [Enter anly one cause per line for (a), (b), and (c), y  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  ONLY  TO SERVE TO SER |                                   |                                    |                         |                                  |  |  |  |  |
| Canditions, if any, which gove rise to immediate DUT TO |  |                                   |                                    |                         |                                  |  |  |  |  |
| lying cause last  | Cause (a), stating the under- lying cause last.  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY  |                                   |                                    |                         |                                  |  |  |  |  |
| CATIC   |  | None                              |                                    |                         |                                  | PERFORMED? YES NO                            |  |  |  |
|   | /AS UNDERLYING ☐ 20b. DE<br>G ☐ CAUSE OF DEATH<br>Y MEDICAL EXAMINER)  | SCRIBE HOW INJURY OCCURRE         | D. (Enter nature of injury i       | in Part I ar Part II af | item 1B.)                        |  |  |  |  |
| Hour o.m.   | 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED Hour o. m.  19 While Not while at wark at wa |                                   |                                    |                         |                                  |  |  |  |  |
| 21. I certify   | that I attended the deced  | ised fram apr 2                   | 1 , 1961 , ta 4                    | M, fram the             |                                  | ast saw the deceased<br>e date stated abave. |  |  |  |
| ACTUAL SIGNATURE  | ACTUAL ADDRESS (Spreet, city or town, state), DATE SIGNED  |                                   |                                    |                         |                                  |  |  |  |  |
| PHYSICIAN'S<br>NAME (Type)                              | BITRAN   | NG GIGH                           | NTI M.                             | <u>)</u>                |                                  | )  |  |  |  |
| 220. BURIAL, CREMATI<br>REMOVAL (Specify<br>Burial      |  | 22c. NAME OF CEMETERY C           | Cemetery                           |                         | city, town, or county) sbury, Ma | ryland                                       |  |  |  |
| 23. FUNERAL DIRECTO                                     | R'S SIGNATURE  | ADDRESS                           | RYLAND DATE                        | C'D BY REGISTRAR        | 24b. REGISTRAR'S SI              |  |  |  |  |
|   | M CONTRIBUTE F   | WINT THOUGHT LIUT                 | TTTTTT JOHN                        |                         |                                  |  |  |  |  |



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FOR STATE HEALTH DEPT. TO DEPUTY MEL.

I. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is meany, please execute the conflicte, writing the word "pending" in pendil in Item 18. Give Pages 1, 2, and 3 to the funeral direction of the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

|               | AGAS MEDICA  | AL EXAMINER'S                   | CERTIFICATE                       | OF DEATH                               | 04938  |
|---------------|--|---------------------------------|-----------------------------------|--|--|
| у.            | PLACE OF DEATH   |                                 |                                   |  | f institution, Residence before edmission)           |
|               | Wicomico   | MARYLAND                        | a. STATE Mary                     | rland b. cou                           | Wicomico   |
| 1             | b. CITY OR TOWN (if outside corporeta limits, write RURAL and give neerest town)       | c. LENGTH OF STAY IN 16         | c. CITY OR TOWN (If ou            | itside corporete limits, wri           | ite RURAL and give neerest town)                     |
|               | Tyaskin  | 1441-5                          | X                                 | lyaskin                                |  |
|               | NAME OF HOSPITAL OR INSTITUTION (if not in   | hospitel, giva street address)  | d. STREET ADDRESS                 |  | IS RESIDENCE     ON A FARM?     YES                  |
| 3.            | NAME OF First DECEASED   | Middle                          | Lest 4.                           | DATE Mon                               | th Dey Yeer  |
|               | (Type or print) Louise   |                                 | Hebron                            | DEATH                                  | 4-13-61 19   |
| 5.            | 6. COLOR OR RACE 7. MAR  | RRIED NEVER MARRIED B           | DATE OF BIRTH 790                 | 9. AGE (In year                        |  |
| 10            | F C WIDO   |                                 | 1425/191                          | 14/1 5 6 yrs.                          |  |
| do            | USUAL OCCUPATION (Give kind of work pine during most of working life; even if retired) | . KIND OF BUSINESS OR INDUSTR   | 11. BIRTHPLACE (State or t        | oreign country)                        | 12. CITIZEN OF WHAT COUNTRY                          |
| 13.           | FATHER'S NAME  | 1                               | 14. MOTHER'S MAIDEN NA            | ME O                                   | 1 1. ):  |
| I             | = 1 1 1 7 = 1  |                                 | M-2010 211                        | [-7]                                   | (: -   |
| 15.           | WAS DECEASED EVER IN U.S. ARMED FORCES?  | 16. SOCIAL SECURITY NO. 17. II  | NFORMANT                          | 8 C & J                                | 013  |
| (Ye           | es, no, or unkown) (Ifyesgivawarordatesofservice)                                      | M.                              | - Falural                         | 07 3/10/1                              | Trus store M   |
| -             | 18. CAUSE OF DEATH [Enter only one cause p   | er line for (a), (b), and (c).] | 37000                             | 76 71114                               | INTERVAL BETWEEN                                     |
|               | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)                                       | Cerebral hemo                   | rrhege-snont                      | canaous                                | ONSET AND DEATH Sudden                               |
|               | 443 X DUE TO   | oor our ar mone.                | THE SOME DOTT                     | anoous                                 | Saaava   |
| Ä             | Conditions, if any, which (b)  | Hypertensive                    | cardio-vascu                      | lar disea                              | se. Years  |
|               | (a), stating the underlying DUE TO   | 1                               |                                   |  |  |
| Ü             | cause last. (c)  |                                 |                                   |  |  |
| CERTIFICATION | PART II. OTHER SIGNIFICANT CONDITIONS C  | CONTRIBUTING TO DEATH BUT NO    | T RELATED TO THE TERMINAL         | DISEASE CONDITION GI                   | VEN IN PART 1(e) 19. WAS AUTOPSY PERFORMED? YES NO W |
|               | 208. EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH.                        | SCRIBE HOW INJURY OCCURED. (E   | ntar netura of injury in Part I o | r Part II of IIem 18.)                 |  |
| MEDICAL       |  |                                 | CE OF INJURY (Home, ferm, '       | 20f. (City or town)                    | (County) (Stete)                                     |
| WED           |  | hile Not While factor           | , silver, clines oldgr, oldr,     |  |  |
|               | 21. I certify that I took charge of the r  | remains described above, hel    | d an Autopsy , Ins                | pection 🔀 Inqui                        | iry X, and in my opinion                             |
|               | death resulted from: Natural causes  | 🗙. Accident 🔲, Suici            | de 🔲, Homicide 🔲                  | . Undetermined r                       | manner   |
|               | £ 0. 1   |                                 | CHIEF MEDICAL EXA                 | MINER [                                |  |
|               | ACTUAL SIGNATURE   | Y-                              | M.D. ASSISTANT MEDICAL            |  | DATE SIGNED  |
|               | EXAMINER'S Earl L. Roye  |                                 | DEPUTY MEDICAL EX                 | H.M                                    | 4-14-61  |
| 220           | BURIAL, CREMATION, 225. DAYE THEREOF   | Ave Salis                       | CREMATORY 220                     | town, or county)  LOCATION (City, town | n, or country) (Stata)                               |
|               | SULYIZ 4/18/6/   | Traskin C                       | em 7                              | 125kin                                 | MJ.  |
| 23            | TONERALDIRECTOR  | / ADDRESS                       |                                   | Y REGISTRAR   246. REG                 | SISTRAR'S SIGNATURE                                  |
| 6             | PNS/19000/12/19  | 106/1/10.                       | DATEPR 1                          | 9 '61 an                               | Elug & Kraus   |

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### CERTIFICATE OF DEATH

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|   | 2343 CERTIFIC  |                                 | CAIL OI   | AIL OF BLAIT            |                        |                                 | Reg. Dist. No. U |               |                    |  |
|---|--|---------------------------------|---|-------------------------|------------------------|---------------------------------|------------------|---------------|--------------------|--|
| 1. PLACE OF DEATH<br>o. COUNTY                              |  |                                 | o. STATE  | esidence (wh<br>Delawar |                        | lived. If institution b. COUNTY | on: Residence    |               | ssign)             |  |
| b. CITY OR TOWN (If RURAL and give neg                      | outside carporate limits, wri<br>arest town)<br>ALISDUTV | te c. LENGTH OF STAY IN         | 1b c. CITY O  | -                       | outside corporo        | te limits, write R              | URAL and give    | e nearest tow | n)                 |  |
| d. NAME OF HOSPITA<br>OR INSTITUTION                        | AL (If not in hospitol, give str                         | Hospital                        |   | ADDRESS                 | enth St                | - 4                             | 16 X-            |               | SIDENCE<br>A FARM? |  |
| 3. NAME OF<br>DECEASED<br>(Type or print)                   | WALTER.  | Middle R.                       | HENRY   | Lost                    | 4. DATE<br>OF<br>DEATH | Mon                             |                  | Day<br>2/     | Year 19 6 /        |  |
| s. sex  |  | ARRIED NEVER MARRIED            | 7   | RTH 188                 |                        | . AGE (In years lost birthdoy)  | Manths Do        | YEAR IF UND   | 1                  |  |
| 10a. USUAL OCCUPATION<br>during most of working<br>Railroad | ng life, even if retired)                                | 06. KIND OF BUSINESS OR II      | NDUSTRY 11. BIRTH   |                         |                        | ntry)                           | USA.             | N OF WHAT     | COUNTRY            |  |
| 13. FATHER'S NAME JOHN F.                                   | . HENRY  |                                 | 14. MOTHER  | COLLIN                  |                        |                                 | 1 000            | 120           |                    |  |
| 15. WAS DECEASED EVER                                       |  | 16. SOCIAL SECURITY NO.         | INFORMANT<br>STELIA HE  |                         | th St.                 | Add                             |                  |               | 2.                 |  |
| CATIC   | he <u>under.</u> (c)  ER SIGNIFICANT CONDITION           | ns <u>contributing to death</u> |   |                         |                        |                                 | 'EN IN PART I    | PERF          | AUTOPSY<br>ORMED?  |  |
| 20c. TIME OF INJURY<br>Hour o. m.                           | Medical Examiner)  Month, Doy, Yeor 20                   | hile Nat while                  | URRED. (Enter noture<br>e. PLACE OF INJUR'<br>foctory, street, of | Y (Hame, farm           | , 20f. (City o         |                                 | (Cau             | unty)         | (State             |  |
|   | at I attended the deci                                   | 1                               | gath occurred o   |                         |                        |                                 |                  | date state    |                    |  |
| 220. BURIAL, CREMATION                                      | 2/24/61  | 22c. NAME OF CEMETER Odd Fellow |   |                         | 22d. LOCATIO           | ON (City, town,                 |                  | (Sto          | ate)               |  |
| 23. FUNERAL DIRECTOR'S                                      | SIGNATURE  | ADDRESS                         | aryland   | 24a. REC'I              | D BY REGISTR           | AR 24b. REGIS                   | STRAR'S SIGN     | 4             |                    |  |

Page 4 a director **D FUNERAL DIRECTOR: W**ifer this certificate has been signed by the attending physician and campletely filled in by the fun page 3 shauld be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld the registrar prior to burial, crematian, ar remaval, and in any event within 72 haurs after death. VING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after d ospital ar attending physician.

may be retained by TO FUNERAL DIRECTOR: TO HOSPITAL OR ATI VS A15 (4) 15M 9/5B ACONS STREET, STREET STREET, STREET, HOLDER TOO SANGER

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If Institution: Residence before admission) a. COUNTY Wicomico b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. CITY OR TOWN (If outside corporete limits, write RURAL and give neerest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Salisbury, Maryland llmo. 2 davs Sharptown, Md. \_= Pages filledi d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS Deer's Head State Hospital etely papers. n 72 hor 3. NAME OF Middle 4. DATE DECEASED OF comple (Type or printWilliam Harrison Hopkins DEATH April carbon part, within 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR last birthdey) and Months Male WIDOWED May 8. 1903 10a. USUAL OCCUPATION (Give kind of work physician ove 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foraign country) done during most of working life, even if retirad) Sharptown, Maryland Farm Day Laborer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please Martha Goslee Leonard Hopkins 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. I 17. INFORMANT (Yes, no. or unkown) | (If yes give wer or dates of service) Mrs. Cordie C. Hopkins . Sharptown. 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), and (c), PART I. DEATH WAS CAUSED BY: Recurrent cerebral thrombosis signed IMMEDIATE CAUSE (a) burial-transit DUE TO Arterbosclerosis general (b) gave rise to immediate cause DUE TO (e), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY 0 use prior 20b. DESCRIBE HOW INJURY OCCURED, (Entar neture of injury in Pert I or Pert II of Item 18.) 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH hed for (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, (County) 20c. TIME OF INJURY 20f. (City or town) Month, Day, Year Not While fectory, street, office bldg., etc. While Hour a.m. et work at work TOR: 21. I certify that (I) (this hospital) attended the deceased from April April 2 19.61 that (I) (we) last ......19.61..., and that death occured a 2:104 M rom the causes and on the date stated above. saw the deceased alive on... DIRE 3 shoul 22a. SIGNATURE ATTENDING DIRECTOR PHYS. PHYS. director, page S 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Salisbury, Maryland 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)
Burial Near Sharptown, Maryland Zion Church demetery April 6, 1961 TO 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE

Lederalsbury mod.

. IS RESIDENCE

YES NO K

19

Hours

INTERVAL BETWEEN ONSET AND DEATH

12 days

PERFORMED?

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(Steta)

1961

U.S.A.

IF UNDER 24 HRS.

ON A FARM?

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death. Page 4

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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# MARYLAND STATE DEPARTMENT OF HEALTH 4952 CEDTIFICATE OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CEDTIFICATE OF STATISTICAL PROPERTY.

CERTIF

|              | DALIMONE I, MARIEMIO |      |
|--------------|----------------------|------|
| ICATE OF DEA | ATH                  | 0494 |
|              |                      |      |

| 1. PLACE OF DEATH   |   |                     |                       |            | 2. USUAL RESIDENCE                                 | F /Where decease    | d lived If instituti         | on Reside  | nce hefo | re admiss  | ion)             |
|---|---|---------------------|-----------------------|------------|--|---------------------|------------------------------|------------|----------|--|------------------|
| o. COUNTY   | Wicom   | ico                 | м                     | ARYLAND    | a. STATE   | yland               | b. COUNTY                    |            |          | ster   | 11               |
| b. CITY OR TOWN ( RURAL ond give n  | If outside carporate lim                            | its, write          | c. LENGTH OF S        | TAY IN 1b  | c. CITY OR TOWN                                    | (If outside corpo   | orate limits, write F        | URAL ond   | give ned | arest town                                       | )                |
| Salisbur  |   |                     | Since 4/1             | 15/59      | Rhodes   | dale                |                              |            |          |  |                  |
| d, NAME OF HOSPI  | TAL (If not in haspitol, s                          |                     |                       |            | d. STREET ADDRE                                    | SS                  |                              |            |          | e. IS RES  |                  |
| OR INSTITUTION Pine Bluff   | State Ho  | spita               | al                    |            |  |                     |                              | 3 =1       | ハン       |  | NO T             |
| 3. NAME OF<br>DECEASED  | Fi  | rst                 | Mi                    | ddle       | Last   | 4. DATE<br>OF       | Mar                          | nth        | Do       | y  | Year             |
| (Type or print) Marion Virginia   |   |                     |                       | a Jackson  | n DEATH  | Apr                 | il                           | 2          | 9        | 961  |                  |
| S. SEX  | 6. COLOR OR RACE                                    | 7. MAR              | RIED NEVER MA         | ARRIED TO  | 8. DATE OF BIRTH                                   |                     | 9. AGE (In years             | IF UNDE    | R 1 YEAR | IF UNDE  | R 24 HRS         |
| Female  | Colored   | WIDOW               |                       | RCED 🔲     | 8/12/191   | 6                   | lost birthdoy) 44 yrs.       | Months     | Days     | Hours  | Min.             |
| 10a. USUAL OCCUPATION   | ON (Give kind of work                               | done 10b.           | KIND OF BUSINES       | SS OR INDU | STRY 11. BIRTHPLACE (                              | State or foreign c  | ountry)                      | 12. CI     | TIZEN OI | WHATC  | OUNTRY           |
| during most of wor  | king life, even if retired                          | 1)                  | None                  |            | Peni   | nsylvani            | ia                           |            | USA      |  |                  |
| 13. FATHER'S NAME   |   |                     | 210110                |            | 14. MOTHER'S MAIL                                  |                     |                              |            |          |  |                  |
|   | les Jackson   | n                   |                       |            |  |                     | Thompso                      | n          |          |  |                  |
| IS. WAS DECEASED EVE  |   |                     | SOCIAL SECURITY       | NO 17 1    | NFORMANT   | 200000              |                              | lress .    |          |  |                  |
| (Yes, no, or unknown)   | (If yes, give wor or dates of                       | service)            |                       |            | Records of   | Dina Di             |                              |            | ogni     | +01  |                  |
| No  |   | <u> </u>            | 19-07-78              | ST .       | kecorus or   | Fine b.             | lull Sta                     | ce m       | ospi     | tal  |                  |
| 18. CAUSE OF DE   | ATH [Enter only one co                              | ouse per li         | ine far (a), (b), ond | (c).]      |  |                     |                              |            | INT      | ERVAL BE   | TWEEN            |
| PART I. DE  | ATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (c            | 2)                  | Amyloi                | doeie      |  |                     |                              |            | 3        | vrs  |                  |
| 001   | DUE TO  |                     | Aug I o I o           | 10313      |  |                     |                              |            |          | <del>*************************************</del> |                  |
| 0 0   |   |                     |                       |            |  |                     |                              |            |          |  |                  |
|   | Conditions, if ony, which (b) Chronic Empyema 5 yrs |                     |                       |            |  |                     |                              |            |          |  |                  |
| couse (o), stoting  | the under-  |                     |                       |            |  |                     |                              |            |          |  |                  |
| lying couse last.   | . ) (0  | c)                  | Pulmon                | ary to     | berculosi  | s                   |                              |            | 1.2      | 2 vr   | S                |
| PART II. OT   | HER SIGNIFICANT CON                                 | IDITIONS            | CONTRIBUTING TO       | DEĂTH BU   | NOT RELATED TO THE                                 | TERMINAL DISEAS     | E CONDITION GI               | VEN IN PA  | RT 1(o)  | 9. WAS   | AUTOPSY<br>RMED? |
| T Y   |   |                     |                       |            |  |                     |                              |            |          |  | NO K             |
| PART II. OT  PART II. OT  PART III. OT  OR CONTRIBUTING  (IF EITHER, NOTIFY | AS UNDERLYING  G CAUSE OF DEATH MEDICAL EXAMINER)   | 20b. DES            | SCRIBE HOW INJUR      | RY OCCURRE | D. (Enter noture of inju                           | ry in Part I or Por | rt II of item 18.)           | - 11       |          |  |                  |
|   |   |                     |                       | les e      |  |                     |                              |            |          |  |                  |
| ZOc. TIME OF INJUI  | RY Month, Doy, Ye                                   | ear 20d.  <br>While | INJURY OCCURRED       |            | ACE OF INJURY (Home<br>ictory, street, office bldg |                     | y or town)                   |            | (County) |  | (Stote           |
| p. m.   | 19  | at wo               | rk at wark            | ]          |  |                     |                              |            |          |  |                  |
| 21 I cortify the  | at (I) (this haspita                                | I) atten            | ded the deceas        | sed from   | April 15   | 1959 ta             | April 29                     | 10         | 61 #     | at (I) (   | we) las          |
|   |   |                     |                       |            | death accurred at                                  |                     |                              |            |          |  |                  |
| 22a. SIGNATURE  |   |                     |                       |            |  |                     |                              | 4 11       | 201      | 221  | b. DATE          |
| - 6   | rritely   | In the              | 1                     |            | M.D. PHYS.   | MED.                | STAFF<br>PHYS.               |            | 4/       | 29/6   | SIGNE            |
| 22c. PHYSICIAN'S<br>NAME (Type)   | E. P. Ritc  | -                   |                       | W.         | 22d. ADDRESS<br>Sal                                | isbury,             | Marylan                      | d          | 4        |  |                  |
| 23a. BURIAL, CREMATIC   | DATE THERE  | O.F.                | 192- NIAME OF         | CEMETERY ( | D CREMATORY  | 224 1004            | TION (Ch. Ac.                |            |          |  |                  |
| REMOVAL (Specify  | May 2. 1  |                     | Petersb               | urg Ce     | metery   |                     | TION (City, town,<br>Hurlock |            |          | (Stat  | e)               |
| 24_FUNERAL DIRECTOR   |   |                     | ADDRESS               |            |  | REC'D BY REGIS      |                              | ISTRAR'S S |          |  |                  |
| J. A. Framp   |   | , Fed               | leasabur              | a, Mar     |  | MAY 1               | 200                          | lithur.    |          |  |                  |

the property of the company of the c THE HEAD SPORTS THE RESIDENCE TO SECURE 

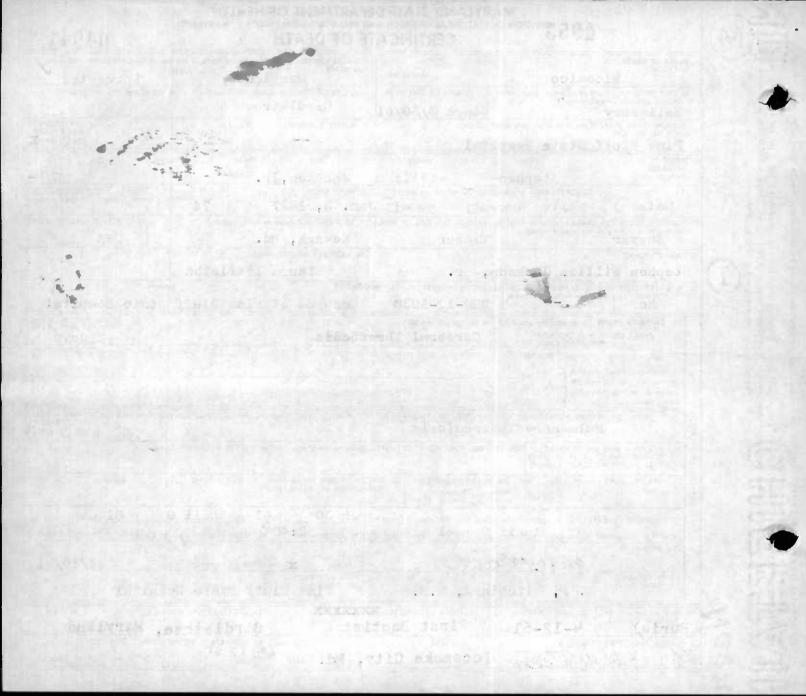
# MARYLAND STATE DEPARTMENT OF HEALTH

01014

|  | 2000   | CERTIF   | FICATE       | OF DEA              | IH                            |                                      |                    | ()4       | 34              | 1                      |
|--|--|--|--------------|---------------------|-------------------------------|--------------------------------------|--------------------|-----------|-----------------|------------------------|
| 1. PLACE OF DEATH o. COUNTY Wic                                | comico   | MAR'   |              | a. STATE            | E (Where deceased             | lived. If instituti<br>b. COUNTY     | ***                | ce before |                 | on)                    |
| b. CITY OR TOWN (If of RURAL and give near Salisbury           | utside corporate limits, s<br>est tawn)  | since 3/30                                       |              |                     | N (If autside carpo<br>Letree | rate limits, write R                 | RURAL and          | give near | est town)       | 1                      |
| d. NAME OF HOSPITAL OR INSTITUTION  Pine Bluft                 | (If not in haspital, give  | street address)                                  |              | d. STREET ADDRE     | SS                            |                                      |                    | e.        |                 | DENCE<br>FARM?<br>NO   |
| 3. NAME OF<br>DECEASED<br>(Type or print)                      | First<br>Stephe  | Middle   | liam         | Jackson             | 4. DATE<br>OF<br>DEATH        | Mor<br>Apri                          |                    | Day<br>9  |                 | ear 9 61               |
| S. SEX Male  | . COLOR OR RACE 7.   | MARRIED NEVER MARRI                              | IED [ 8. D.  | n. 5, 18            |                               | 9. AGE (In years last birthday) yrs. | IF UNDER<br>Months | 1 YEAR I  | Hours           | R 24 HR                |
| Oa. USUAL OCCUPATION during most of working Sawyer             | (Give kind of work don<br>g life, even if retired)   | e 10b. KIND OF BUSINESS O                        | OR INDUSTRY  | Newark,             |                               | ountry)                              |                    | USA       | WHATCO          | OUNTRY                 |
| 3. FATHER'S NAME Stephen Wil                                   | lliam Jacks  | son, Sr.   | 14           | Lau                 | DEN NAME<br>Ura Litt          | leton                                |                    |           |                 |                        |
|  | N U. S. ARMED FORCES   | 16. SOCIAL SECURITY NO<br>220-12-196             |              |                     | of Pine                       |                                      | State              | Hos       | pita            | al                     |
| PART I. DEATH  | [Enter only one cause<br>WAS CAUSED BY:<br>MMEDIATE CAUSE (a)  | per line for (o), (b), and (c)  Cerebral         |              | bosis               |                               |                                      |                    | ONSE      | T AND           | DEATH                  |
|  | DUE TO  c) c)  SIGNIFICANT CONDIT  | ions contributing to de<br>T <b>uberculosi</b> s | EATH BUT NO  | T RELATED TO THE    | TERMINAL DISEAS               | E CONDITION GI                       | VEN IN PAR         | - 1       | . WAS A PERFOIL | AUTOPSY<br>RMED?<br>NO |
| 200. ACCIDENT WAS<br>OR CONTRIBUTING L<br>(IF EITHER, NOTIFY M | UNDERLYING 20<br>CAUSE OF DEATH<br>EDICAL EXAMINER)  | b. DESCRIBE HOW INJURY O                         | OCCURRED. (E | nter noture of inju | ery in Port I ar Por          | t II of item 18.)                    |                    |           |                 |                        |
| 20c. TIME OF INJURY Hour a. m. p. m.                           | 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED Hour a. m.  While Not while of work at work.   |  |              |                     |                               |                                      |                    |           | (Stote          |                        |
| 21. I certify that<br>saw the deceased<br>220. SIGNATURE       | 21. I certify that (I) (this haspital) attended the deceased from March 30 1961, ta April 9 1961, that (I) (we) lost saw the deceased olive an April 9 1961, and that death occurred 2640 M, from the causes and on the date stated above. |  |              |                     |                               |                                      |                    |           |                 |                        |
| 22c. PHYSICIAN'S<br>NAME (Type)                                | grepete  |  | M.D.         | 22d. ADDRESS        |                               | STAFF PHYS.                          |                    | 4         | /10/            | SIGNE<br>/61           |
| 230. BURIAL, CREMATION,<br>REMOVAL (Specify)                   |  | chings, M.D.  23c. NAME OF CEN  First            | AETERY &XI   | ZONNOWX             | 1-1-1                         | TION (City, town,                    | or county)         |           | (Stote          | e)                     |
| 24. FUNERAL DIRECTOR'S   |  | ADDRESS Pocomoke                                 |              | 250                 | REC'D BY REGIST               | RAR 25b. REG                         | ISTRAR'S SI        | GNATUR    | E               |                        |

a directar, be filed with Poge 4 **DEUNERAL DIRECTORY** After this certificate has been signed by the attending physician and completely filled in by the fupage 3 should be detached for use as the burial-transit permit. Then please remaye corban papers. Pages 1 and 2 shauld the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 haurs after death. JING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs after ospitol or ottending physician.

moy be remined by TO FUNERAL DIRECTOR TO HOSPITAL OR ATT VR A1S (4) 1SM 9/59



# FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 4954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14949

|   | () 10 - 0   |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission  |  |  |  |  |  |  |
| Wicomico MARYLAND   | Maryland b. COUNTY Wicomico   |  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporete limits,   c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town)  |  |  |  |  |  |  |
| write RURAL and give nearest town)  | 317 Poplar Hill Ave.  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give streat address)  | d. STREET ADDRESS  o. IS RESIDENCE ON A FARM?   |  |  |  |  |  |  |
| Danimania Comenci Hearitel  | Salisbury   |  |  |  |  |  |  |
| Peninsula General Hospital  3. Name OF Middle   | Lest 4. DATE Month Dey Yeer   |  |  |  |  |  |  |
| DECEASED (Type or print)  | ckson Je 1/1- 1/1- 619  |  |  |  |  |  |  |
| 5. SEX   COLOR OR RACE   7. MARRIED   NEVER MARRIED   8.  | DATE OF BIRTH 9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.   |  |  |  |  |  |  |
|   | lest birthdey) Months Days Hours Min.   |  |  |  |  |  |  |
| 1De. USUAL OCCUPATION (Give kind of work   10b. KIND OF BUSINESS OR INDUSTRY  | 0/20/1900   |  |  |  |  |  |  |
| done during most of working life, aven if retired)  | 77.60   |  |  |  |  |  |  |
| Laborer Oil   | Virginia  14. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |
| Cornelius Jackson  15. WAS DECEASED EVERUN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. IN  | Jane ( NFORMANT Address Salisbury, Md   |  |  |  |  |  |  |
| (Ves no or unknown) [[[fyasgivewerord#esofservice]]   |   |  |  |  |  |  |  |
| NO MTS  1 18. CAUSE OF DEATH [Enter only one cause per lime for (a), (b), end (c).]   | . Viola Jackson, 317 Poplar Hill Ave.,  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  | ONSET ADD DEATH   |  |  |  |  |  |  |
| IMMEDIATE CAUSE (e)   | y years   |  |  |  |  |  |  |
| 420, DUE TO 1 DE C  | No Verne  |  |  |  |  |  |  |
| Conditions, if eny, which gave rise to immediate cause  | Yara  |  |  |  |  |  |  |
| (e), steting the underlying DUE TO  |   |  |  |  |  |  |  |
| causa last. (c)   | PRINTED TO THE TENNINAL DISEASE COMPLETENT CHARLES IN THE PRINTED TO THE PRINTED |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT   | RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?   |  |  |  |  |  |  |
| CAT   | YES NO  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT  200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTIONS | nter nature of injury in Part I or Part II of item 1B.)   |  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |
|   | CE OF INJURY (Homa, farm, ' 20f. (City or town) (County) (Stata)  rry, street, offica bldg., etc.)  |  |  |  |  |  |  |
| p.m. 19 at work at work   |   |  |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held   | d an Autopsy . Inspection X, Inquiry X, and in my opinion   |  |  |  |  |  |  |
| death resulted from: Natural causes 🔭 Accident 🗍, Suicident   | de , Homicide , Undetermined manner   |  |  |  |  |  |  |
|   | CHIEF MEDICAL EXAMINER  |  |  |  |  |  |  |
| ACTUAL SIGNATURE EN C   | M.D. ASSISTANT MEDICAL EXAMINER [ ] DATE SIGNED   |  |  |  |  |  |  |
| EXAMINER'S Earl L. Royer, M.D.  | DEPUTY MEDICAL EXAMINER   |  |  |  |  |  |  |
| NAME (Typa) 107 Camden Ave. Salist  | unyAddrag Streat, city, town, or county) 1-17-61  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, 12b. DATE THEREOF 22c. NAME OF CEMETERY OF  | CREMATORY 22d. LOCATION (City, town, or country) (State)  |  |  |  |  |  |  |
| Burial 4/19/1960 Green Acre Cem   | Salisbury, Ma<br>  248. REC'D BY REGISTRAR   246. REGISTRAR'S SIGNATURE   |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR ADDRESS  | 24a. REC'D BY REGISTRAR   24b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |

DATAPR 2 0 '61

Ciriling & Kraus

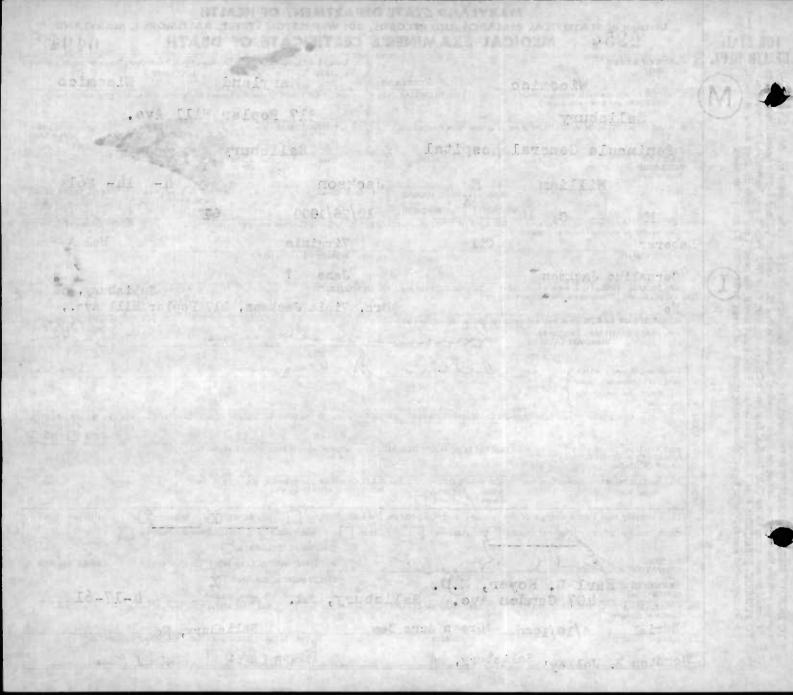
Jolley, Salisbury, Md

TO DEPUTY MED.

LEXAMINER: This certificate should be executed within 24 hours after death. If any delay is ne please execute the certificate, writing the word "pending" in pendil in Item 18. Give Pages 1, 2, and 3 to the funeral direct. Fage 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any gent within 72 hours after death. VS. A15ME 5M 7/59

Thornton B.



# funeral ours after TO HOSPITAL OR TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frou a death. Page 4 may retained by the hospital or attending physician. Yelengthis to the properties of the

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 43

|    | 1. PL                               | ACE OF DEATH   |                                       |                             | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) |                        |  |               |                     |  |  |
|----|-------------------------------------|--|---------------------------------------|-----------------------------|---|------------------------|--|---------------|---------------------|--|--|
|    | a. (                                | Wicomico   |                                       | MARYLAND                    | e. STATE  | -1 d                   | b. COUNTY  | ahaat.        |                     |  |  |
| 3  | b. (                                | CITY OR TOWN (if outside con                                 | porata limits                         | c. LENGTH OF STAY IN 1b     |   | yland                  | e limits, write RURAL a                          | cheste        |                     |  |  |
|    |                                     | write RURAL and give neerest                                 |                                       |                             |   | Trouvilla corporati    |  | 3 0           | 1                   |  |  |
|    |                                     | Salisbur   | 7                                     | 23 Days                     | Camb  | bridge                 |  |               |                     |  |  |
|    | d.                                  | NAME OF HOSPITAL OR INST                                     | ITUTION (if not in hosp               | pital, give streat eddress) | d. STREET ADDRESS   |                        |  |               | ON A FARM?          |  |  |
| 1  |                                     |  | ead State H                           |                             |   |                        | ton Street                                       |               | ES NO               |  |  |
|    | DE                                  | AME OF<br>CEASED   | First                                 | Middle                      | Last  | 4. DATE<br>OF<br>DEATH | Month  | Day           | Yeer                |  |  |
|    |                                     | pa or print)   | Julia                                 | Kiah                        | Johnson   |                        | April  | 28            | 19 61               |  |  |
|    | 5. SEX                              | X 6. COLOR   | OR RACE 7. MARRIED                    | NEVER MARRIED   8           | . DATE OF BIRTH   | 9. A                   | GE (In yaers   IF UNDER<br>st birthdey)   Months |               | UNDER 24 HRS.       |  |  |
|    |                                     | emale Negr   |                                       | DIVORCED _                  | August 26,  | 1881                   | 7.9 yrs.   |               | lours Min.          |  |  |
|    | dona                                | JSUAL OCCUPATION (Give ki<br>during most of working life, ev | nd of work<br>en If retired) 10b. KII | ND OF BUSINESS OR INDUSTR   |   |                        |  |               | HAT COUNTRY?        |  |  |
|    |                                     | None   |                                       | None                        | Madiso  | on, Mary               | Land   | U.S.          | . A.                |  |  |
| 31 | 13. FA                              | ATHER'S NAME   |                                       |                             | 14. MOTHER'S MAIDEN   | NAME                   |  |               |                     |  |  |
|    |                                     | William M  | daton                                 |                             | Deboo   | Car                    |  |               |                     |  |  |
| 1  | 15. W                               | 'AS DECEASED EVER IN U.S. A                                  | RMED FORCES?   16.                    | SOCIAL SECURITY NO.   17.   | Rebec   | ca car                 | nady   | -             |                     |  |  |
|    | (Yas, r                             | no, or unkown)   (Ifyesgivewer                               | ordetes of service)                   |                             |   |                        |  | 26            |                     |  |  |
| /  | - 1                                 |  |                                       | Unk.                        | Hospital B  | decords -              | - Salisbur                                       |               |                     |  |  |
|    | 18                                  | CAUSE OF DEATH  Ente   | //                                    | ne for (e), (b), end (c),   | / .   |                        |  |               | AND DEATH           |  |  |
| Н  |                                     | PART I. DEATH WAS CAU  |                                       | brail the                   | m tosis   | -                      |  | 2             | yes                 |  |  |
|    | 11 3                                | 331X   | DUE TO C                              |                             | 1 1   |                        | 1  | 6             |                     |  |  |
|    | l c                                 | onditions, if any, which                                     | " Kli                                 | uesali-                     | O alles   | in pal                 | kroses   | 10            | un.                 |  |  |
|    |                                     | eva rise to immediate ceuse                                  | (6)                                   | and and                     | Coroca  | -UNCE                  |  |               | 1                   |  |  |
|    | (a), stelling the underlying DUE TO |  |                                       |                             |   |                        |  |               |                     |  |  |
|    | C8                                  | suse last.   | (c)                                   |                             |   |                        |  |               |                     |  |  |
|    | O                                   | PART II. OTHER SIGNIFICAN                                    | AT CONDITIONS CON                     | TRIBUTING TO DEATH BUT NO   | OT RELATED TO THE TERMI   | NAL DISEASE CON        | NDITION GIVEN IN PAR                             | RT 1(a) 19. \ | PERFORMED?          |  |  |
|    | E.                                  |  |                                       |                             |   |                        |  | YES           |                     |  |  |
|    |                                     | . ACCIDENT WAS UNDERLY                                       |                                       | CRIBE HOW INJURY OCCURED    | . (Enter netura of injury in  | Pert I or Part II of   | item 18.}  |               |                     |  |  |
|    |                                     | R CONTRIBUTING CAUSE CE EITHER, NOTIFY MEDICAL ES            |                                       |                             |   |                        |  |               |                     |  |  |
| ñ  |                                     |  | .,                                    |                             | CE OF INJURY (Home, ferr  |                        | town) (Co  | ounty)        | (Stete)             |  |  |
| ī  | WEDI                                | Hour a.m.  | While<br>19 at work                   | 1401 47 11116               | lory, street, office bldg., etc   | -/                     |  |               |                     |  |  |
|    |                                     | p.m.   |                                       |                             | 1./4/67   | 10                     | 1./00/67 10                                      | 2 .1 .1       | (1) ( ) 1           |  |  |
|    |                                     | . I certify that (i) (th                                     | is hospital) attend                   | ded the deceased from.      | 4/.5/.OL  | 19, 10                 | .44.50/.01, 12                                   | /, that       | (I) (We) last       |  |  |
|    |                                     | aw the deceased alive  | on 41.00/.01                          | 19, and that                | death occured atO.  | L.M, from th           | ne causes and on                                 | the date      | stated above.       |  |  |
|    | 2:                                  | 28. SIGNATURE  | UP                                    |                             | ATTENDING   | 2.5                    | STAFF  |               | 22b. DATE<br>SIGNED |  |  |
|    |                                     | heid   | hall                                  | MIN N                       | .D. PHYS. X   |                        |  | April         | 29, 196             |  |  |
|    | 22                                  | 2c. PHYSICIAN'S  | 0,000                                 | 7                           | 22d. ADDRESS  |                        |  | - 1           |                     |  |  |
|    |                                     | NAME (Type) Lee ]  | L. Lawry, M                           | 1.0.                        |   | Salisbury              | , Maryland                                       |               |                     |  |  |
| V. | 23a. 1                              | BURIAL, CREMATION, 23b.                                      |                                       | 23c. NAME OF CEMETERY       |   |                        | ON (City, town or cour                           |               | (State)             |  |  |
|    | RE                                  | MOVAL (Specify)  |                                       | 2 11 2 6                    |   | 0                      |  |               |                     |  |  |
| ₹  |                                     |  | 2/1961                                |                             | netery  |                        | ridge, Md  |               |                     |  |  |
|    | 24 50                               | NERAL DIRECTOR'S SIGNATU                                     | RE                                    | ADDRESS                     |   | C'D BY KEGISTRA        | R 25b. REGISTRAR'S                               | SIGNATUR      | ž                   |  |  |
| 1  | 1/1                                 | theely 1/18  | flats fl                              | — Cambridge                 | , Md. DATEM   | AY 3 '61               | Guttun &   | 2 4           |                     |  |  |
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before a. COUNTY b. COUNTY Maryland Wicomico MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 1h write RURAL and give nearest town) Board of Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address) Princess Anne d. STREET ADDRESS retained f he State Bu death. Peninsula General Hospita] 4. DATE Month DECEASED OF the (Type or print) age 5 may be re 1 and 2 with the 72 hours after o DEATH Lee 1-19-61 death. I Larmore 6. COLOR OR RACE 7. MARRIED ANEVER MARRIED B. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR Jan. 21, 1900 last birthdey) and WIDOWED [ DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Page done during most of working life, even if retired) 18. Give Pages 1, the form PM3. Pagrant. File pages 1 styles are avent within 7. Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles Larmore Ruth Hickman with form permit. File IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give we ror dates of service) Princess Anne, Md. Larmore any 1B. CAUSE OF DEATH [Enter only one cause per ling for (a), (b), and (c).] along v transit p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Office DUE TO burial removal, Conditions, if eny, which (6) gava rise to immediate cause AL EXAMINED. The Spending confidence of the Chief Medical Examiner's ECTOR: Page 3 should be used as a sent. prior to burial, cremation, or remainer to burial. N CO DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of itam 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, Month, Day, Year 20f. (City or town) factory, street, office bldg., etc.) Not While While orwarded to the DIRECTOR: Page agent, prior t et work at work Inspection | 21. I certify that I took charge of the remains described above, held an Autopsy to Inquiry forwarded death resulted from: Natural causes Y Homicide Accident Suicide Undetermined manner CHIEF MEDICAL EXAMINER designated should be for FUNERAL D ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) NAME OF CONTENT OF CREMINARY 22d. LOCATION (City, town, or country) 220. BURIAL, CREMATION, burial (Specify) 240 g Rehobeth Presbyterian Rehobeth, 23. FUNERAL DIRECTOR 24e. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE VS. A15ME Princess Anne, McDate APR 27'61 Civilian & Krous

MARYLAND STATE DEPARTMENT OF HEALTH

e. IS RESIDENCE ON A FARM?

YES NOTE

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19

Hours

INTERVAL BETWEEN

ONSET AND DEATH

PERFORMED? NO F

(State)

and in my opinion

DATE SIGNED

12. CITIZEN OF WHAT COUNTRY?

U.S.

Months

Deys

(County)

IF UNDER 24 HRS.

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NING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter

ospitol or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CEPTIFICATE OF DEATH

| D. CCITY WICOMICO  MARYLAND  D. CITY OR TOWN (If outside corporate limits, write to clerk of STAY IN 1b  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL SOUTH (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL and give necreal form)  SCHOOL TOWN (If outside corporate limits, write PURAL AND AND AND FOR FURAL ENTRY IN The SCHOOL TOWN (If outside corporate limits, write PURAL AND AND FOR FURAL ENTRY IN The SCHOOL TOWN (If outside corporate limits, write PU | 70116   | CERTIFICA                      | IL OI DEATH                       |                            | 114443   |
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| ALTERNAL PART LOCATION (In kind of Brockers)  18. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  18. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  18. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course per line for (e), (b), and (c).  19. CAUSE OF DEATH [Enter only one course one of more death amount of more de | PLACE OF DEATH O. COUNTY WICOMICO   | MARYLAND                       | o. STATE Mary                     | land b. COUNTY             | Wicomico   |
| NAME OF DECEASED PLAND   SAME OF DECEASED   SECONDARD   SAME   SAME OF DECEASED   SECONDARD   SAME OF DECEASED   SAME OF DECEASED   SAME OF BETTH   SECONDARD   SAME OF DECEASED   SAME OF DECEAS | b. CITY OR TOWN (If outside corporate limits, v<br>RURAL and give nearest town)<br>Salisbury (Ru  | rite c. LENGTH OF STAY IN 16   |                                   |                            | L ond give nearest town)                             |
| NAME OF   CLIMEN   THOMS   LEONARD   Cost   Option   Op   | d. NAME OF HOSPITAL (If not in hospitol, give OR INSTITUTION D.# 3  | street oddress)                |                                   | # 3                        | e. IS RESIDENCE<br>ON A FARM?<br>YES NO              |
| Male White WIDOWED DIVORCED March 24, 1898 6 3 yr.    DIVORCED DIVORCED   DIV | NAME OF First DECEASED DT MED   |                                |                                   | Ar.                        |  |
| FATHER'S NAME  HATTY LEONARD  WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. MINORMANT CAUSE (BY). MAY DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. MINORMANT MAY DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. MINORMANT MAY DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. MINORMANT MAY DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. MINORMANT MAY DECEASED BY. MAY DEATH MAY CAUSE (BY). MAY DEATH MAY DEATH MAY CAUSE (BY). MAY DEATH  | Mada Mada   |                                |                                   | lost hirthdoy)             |  |
| Harry Leonard  WAS DECEASED EVER IN U. S. ARMED FORCES? (a. SOCIAL SECURITY NO. Mrs Salisbury, Maryland  18. CAUSE OF DEATH [Enter only one couse per line for (o). (b). ond (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)  Conditions, if ony, which gove rise to immediate couse (o). The significant contribution of the period of th | dr. USUAL OCCUPATION (Give kind of work done<br>during most of working life, even if retired)   |                                | **                                |                            | 12. CITIZEN OF WHAT COUNTRY?                         |
| WAS DECEASED EVER IN U. S. ARMED FORCES?  In you, give we are detended envised.  16. SOCIAL SECURITY NO.  MINFORMANT THAN E Least (Wife) R.D.# 3  18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIAL CAUSE (o)  DUE TO  Conditions, if ony, which gove rise to immediate couse (o), storing the under yilling couse (o), storing the under living couse lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPS PERFORMED?  YES NO TO CONTRIBUTING ID CAUSE OF DEATH NA AUTOPS PERFORMED?  YES NO TO CONTRIBUTING ID CAUSE OF DEATH NA AUTOPS PERFORMED?  YES NO TO CONTRIBUTING ID CAUSE OF DEATH NA AUTOPS PERFORMED?  YES NO TO CONTRIBUTION DEATH DOWN TO COUNTRY HOME, form, p. m. N/A 19 204. INJURY OCCURRED While Not wink of work of wo | 3. FATHER'S NAME  |                                |                                   |                            |  |
| INTERVAL BETWEEN ONLY   INTE   | Harry Leonard   |                                |                                   |                            |  |
| INTERVAL BETWEEN ONLY   INTE   | S. WAS DECEASED EVER IN U. S. ARMED FORCES  (If yes, give wor or dates of service  (If yes, give wor or dates of service)               | ? 16. SOCIAL SECURITY NO. Mr   | Salisbury.                        | Leonard (Wife)<br>Maryland | R.D.# 3  |
| PERFORMED? YES NO NO YES NO | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO  Conditions, if ony, which gove rise to immediate couse (o), stoting the under- | Chybrage 9                     | nyreard                           | titis                      |  |
| Hour o. m. p. m.  N/A  19  While of work of wo | 20g. ACCIDENT WAS UNDERLYING 201 CONTRIBUTING CASE OF DEATH   | b. DESCRIBE HOW INJURY OCCURRE | -1B'                              | 00                         | IN PART 1(o) 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO |
| saw the deceased alive an I Maryland 196, and that death accurred at Maryland 22b. Date of the course and an the date stated above 22c. SIGNATURE  M.D. PHYS. MED. STAFF April 22b. DATE OF PHYS. April 919  22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis 22d. Address Willards, Maryland  a. BURIAL, CREMATION. REMOVAL (Specify) Apr. 12, 1961 Wicomico Mem. Park Salisbury, Maryland  FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25c. REC'D 8Y REGISTRAR'S SIGNATURE   | Hour o.m. N/A 10  | While Not while for            | ctory, street, office bldg., etc. | )                          | (County) (State                                      |
| April 999  22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis 22d. Address Willards, Maryland  a. BURIAL, CREMATION, REMOVAL (Specify) Apr. 12, 1961 Wicomico Mem. Park Salisbury, Maryland  FUNCEAL DIRECTOR'S SIGNATURE ADDRESS 250. REC'D 8Y REGISTRAR'S SIGNATURE   | 0 6   | 11 -                           |                                   | // //                      |  |
| NAME (Type) Dr. Frank R. Lewis Willards, Maryland  a. BURIAL, CREMATION. REMOVAL (Specify) Burial Apr. 12, 1961 Wicomico Mem. Park Salisbury, Maryland  FUNERAL DIRECTOR'S SIGNATURE  Willards, Maryland  Solisbury, Maryland  Solisbury, Maryland  250. REC'D 87 REGISTRAR 250. REGISTRAR'S SIGNATURE   | Trank June  | 2                              |                                   | D. STAFF PHYS. A           | pril // 22b. DATE SIGNE                              |
| Burial Apr. 12, 1961 Wicomico Mem. Park Salisbury, Maryland  FUNERAL DIRECTOR'S SIGNATURE ADDRESS 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE   | 22c. PHYSICIAN'S NAME (Type) Dr. Frank R.   | Lewis                          |                                   | , Maryland                 | ,  |
| 200 0 4 304  | 3d. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Apr. 12, 1   |                                |                                   | Salisbury, M               | laryland   |
|  | 4. FUNERAL DIRECTOR'S SIGNATURE   |                                | con                               |                            |  |

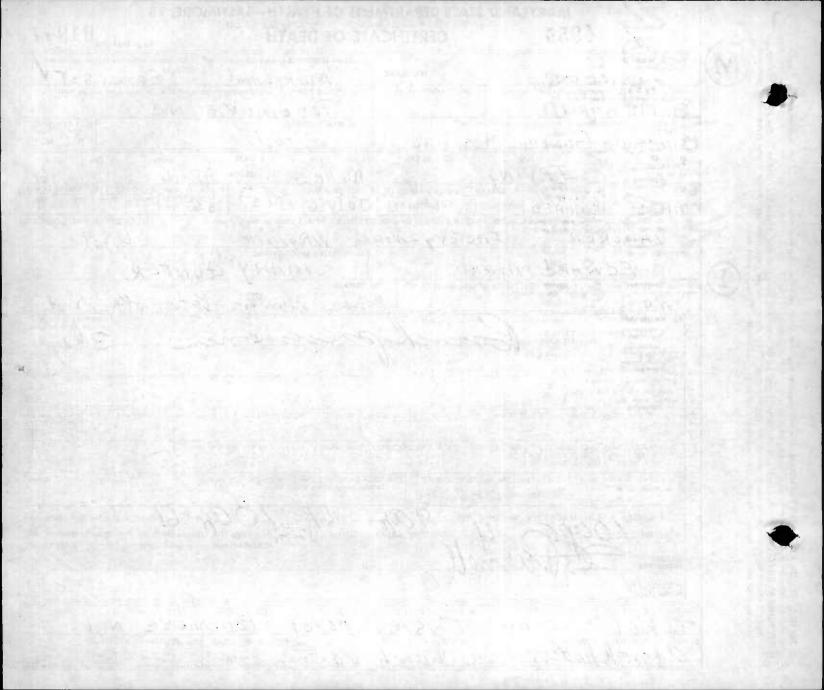
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WARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before edmission) e. COUNTY b. COUNTY Wicomico Wicomico MARYLAND b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL end give neerest town) ould be executed within 24 hours after death. If any delay is no "in pencil in Item 18. Give Pages 1, 2, and 3 to the funerel direct Office along with form PM3. Page. 5 may be retained for you burial-transit permit. File pages 1 and 2 with the State Board of movel, and in any event within 72/fours after death. Salisbury Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? Commerce St. (Vacant Lot) 402 Atlantic Ave. YES NO Z 3. NAME OF Middle DATE DECEASED OTTIS (Type or print) TAFT MEADOWS APRII 1967 DEATH 2nd 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. lest birthday) Months WIDOWED [ DIVORCED 10a. USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Railroad (Brakeman Railroading Kinston, North Carolina 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Tobe Meadows Mary McDuffv 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Mae Meadows (Wife) 402 Atlantic (Yes, no, or unkown) | (If yes give wer or detes of service) rs. Eloise Unk Salisbury, Maryland Ave. 1B. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Acute alcoholism Sudden IMMEDIATE CAUSE (a) removal, DUE TO certificate should rd "pending" in pe Conditions, if eny, which (b) geve rise to immediate cause DUE TO (a), steting the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6): 19. WAS AUTOPSY CERTIFICATION PERFORMED? YES NO 2De. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED. (Enter neture of Injury in Pert I or Pert II of item 18.) PRIMARY | or CONTRIBUTING | lease execute the conflicate, writing massional be forwarded to the Chief Meshould be forwarded to the Chief Meshould be proved and conflicate to buriel, CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, ! 20f. (City or town) (County) (State) fectory, street, office bldg., etc.) While Not While Hour e.m. et work et work 21. I certify that I took charge of the remains described above, held an Autopsy X Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER T DATE SIGNED SIGNATURE DEPUTY Rover DEPUTY MEDICAL EXAMINER NAME (Type) Ave Salisbury, Md Add Camden Address (Street, city, town, or county) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or country) REMOVAL (Specify) Apr. 6.1961 Barrett Chapel Cem. Near Fredrica, Delaware 0 940 Ö Burial 23. FUNERAL DIRECTOR ADDRESS 24e. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE VS. A15ME anthun S. Flower HOLLOWAY & COMPANY DATE APR 5 5M 7/59 SALISBURY MARYLAND

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RYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Whare decaesad lived, If institution: Rasidanca balore edmission a. COUNTY e. STATE b. COUNTY Wicomico Maryland MARYLAND b. CITY OR TOWN (if outside corporeta limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (II outside corporate limits, write RURAL and give nearest town) Board of write RURAL and give neerest town) Salisbury
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ocean City d. STREET ADDRESS ould be executed within 24 hours after death. If any delay "in pencil In Item 18, Give Pages 1, 2, and 3 to the funeral Office along with form PM3, Page 5 may be retained fo burial-transit permit. File pages 1 and 2 with the State Bomoval, and in any event within 72 hours after death. Peninsula General Baltimore 3. NAME OF Middla DATE Month DECEASED OF (Type or print) DEATH LINGTON rthur 1-9-67 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX B. DATE OF BIRTH 9. AGE (In years IT UNDER I YEAR last birthday) Months WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) done during most of working life, even if retired) State Trooper

13. FATHER'S NAME Maryland Police 14. MOTHER'S MAIDEN NAME, 1 16. SOCIAL SECURITY NO. | 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) | (If yes giva war or date of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Fracture of skull IMMEDIATE CAUSE (a) DUE TO removal, This certificate should word "pending" in p Conditions, il any, which (b) LEXAMINER.

Afficate, writing the word "pending" is better the Chief Medical Examiner's Of TOR: Page 3 should be used as a bit of the CTOR. gave rise to immadiate cause DUE TO (e), steting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION 200. EXTERNAL CAUSE WAS PRIMARY POR CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of Injury in Pert I or Part II of itam 18.) forwarded to the Chief Me I. DIRECTOR: Page 3 sho afed agent, prior to burial, CAUSE OF DEATH. Injured in plane that crashed on take 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, ) 20f. (City or town) Month, Day, Year fectory, street, office bldg., etc.) Whlla Not While Hour e.m. et work et work Assateague Island ease execute the conflicate, should be forwarded to the FUNERAL DIRECTOR: 21. I certify that I took charge of the remains described above, held an Autopsy | Inspection X Inquiry designated agent, death resulted from: Suicide Homicide Undetermined manner Natural causes Accident CHIEF MEDICAL EXAMINER 0 ACTUAL ASSISTANT MEDICAL EXAMINER M.D. SIGNATURE

0 VS. A15ME 5M 7/59

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DEPUTY

OH

Salisbury.

amden

EXAMINER'S

220- BURIAL, CREMATION 221

REMOVAL (Specify)

NAME (Type)

23. FUNERAL DIRECTOR

240. REC'D BY REGISTRAR I 24b. REGISTRAR'S SIGNATURE

22d, LOCATION (City, town, or co

DEPUTY MEDICAL EXAMINER

Tory

isbury

ERGREEN CEMETER

ADDRESS

Worcester

IS RESIDENCE

ON A FARM?

YES NO

Year

19

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? NO T

> > (State)

and in my opinion

DATE SIGNED

Va

12. CITIZEN OF WHAT COUNTRY?

US

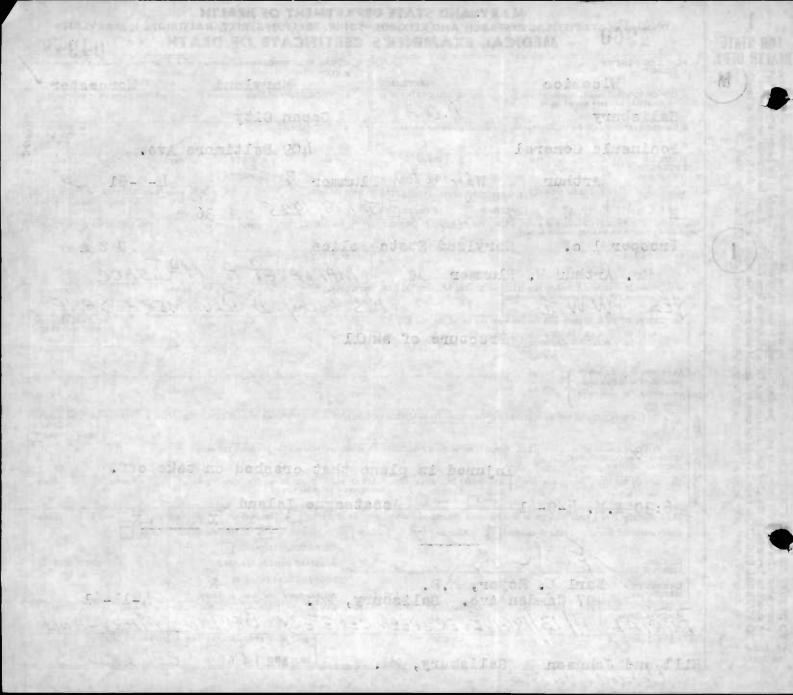
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(County)

IF UNDER 24 HRS.

Min.

DATE APR 1 4 '61 Circles S. Frank



PRESTON STREET, BALTIMORE 1, MARYLAND FOR STATE MEDICAL EXAMINER'S IFAITH DEP PLACE OF DEATH 2. USUAL RESIDENCE (Where daceased lived, If institution: Residence before edmission) a. COUNTY files. Health, 966 a. STATE b. COUNTY MARYLAND Maryland Worcoster
c. CITY OR TOWN (If outside corporete limits, write RURAL and give naerest lown) Wicomico b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give neerest town) ō for your rould be executed within 24 hours after death. If any delay is ne in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral direct Office along with form PM3. Page 5 may be retained for you burial-transit permit. File page 1 and 2 with the State Board o moval, and in any event within 22 hours after death. d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) IS RESIDENCE ON A FARM? Peninsula General Hospital YES NO Last 4. DATE Month Year DECEASED OF (Type or print) HRLES DEATH 19 6. COLOR OR RACE 7 MAI Purnell 1-9-67 AGE (In yeers IF UNDER I YEAR S. SEX 8. DATE OF BIRTH IF UNDER 24 HRS. 7. MARRIED P NEVER MARRIED lest birthdey) Months WIDOWED DIVORCED USUAL OCCUPATION (Give kind of work 1Db. KIND OF BUSINESS OR INDUSTRY | 11. 12. CITIZEN OF WHAT COUNTRY? done during most of working life, avan if retired) Atlantic Hotel Vice-President 14. MOTHER'S MAIDEN NAME 5 5 10 16. SOCIAL SECURITY NO. or unknwn) ((fives give wer or detec of service) WURLD W CAUSE OF DEATH [Entar only one ceuse per lina for (e), (b), and (c).] ONSET AND DEATH I. DEATH WAS CAUSED BY: Fracture of skull IMMEDIATE CAUSE (e) DUE TO removal, Conditions, if any, which (b) lease execute the carricate, writing the word "bending" should be forwarded to the Chief Medical Examiner's C PUNERAL DIRECTOR: Page 3 should be used as a brits designated agent, prior to burial, cremation, or rem gava risa to Immadiate cause DUE TO (e), stating the underlying causa last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19. WAS AUTOPSY CERTIFICATION PERFORMED? NOX 2Da. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING 20b. DESCRIBE HOW INJURY OCCURED, (Entar nature of injury in Part I or Part II of itam 18.) CAUSE OF DEATH. plane crashed in take off. Injured when MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Homa, farm, | 20f. (City or town) 20c. TIME OF INJURY Month, Dey, Year (County) (Slate) factory, street, office bldg., etc.) While Not While at work at work Assateague 21. I certify that I took charge of the remains described above, held an Autopsy | | Inspection X Inquiry X and in my opinion Undetermined manner Homicide | death resulted from: A Natural causes Accident Suicide CHIEF MEDICAL EXAMINER ACTUAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY 4-11-61 Rover EXAMINER'S NAME (Type) Add (Street, city, town, or county) Shury Ad 22a, BURIAL, CREMATION. 22d. LOCATION (City, town, or country) (Stete) REMOVAL (Specify) 0 P40 0 66 SURIA 24a. REC'D BY REGISTRAR | 24b, REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR VS. AISME DATE APR 1 arthur S. France 5M 7/59 4 Home, Berlin. Md. Funeral

MARYLAND STATE DEPARTMENT OF HEALTH

telented to bushes the second columnia vald macon TATEL S Sallyan Sergen allend of CHILLE Mandelle and Turnell Tark PC PARTER BUILDING TO THE PERSON OF THE PERS Tigo- postdont wistlantic dotal a Comme Cory Maria U. SH De la caracter de la contracte Vis Warmanas - What & Tilve mere Deen of the DENIE TO AUDITOR The sold at behave emelt and beautiful 

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4962. **CERTIFICATE OF DEATH** Page 4 directar,

|   |       | -     | 02/1111         |          |        | R               | eg. Dist. | No.    | AC    | 15  | 1 |
|---|-------|-------|-----------------|----------|--------|-----------------|-----------|--------|-------|-----|---|
| ĺ | 2. US | UAL R | ESIDENCE (Where | deceased | lived. | If institution: | Residence | before | odmis | ian | U |
| ı | a.    | STATE | Dolan           |          |        | COUNTY          |           | 551    |       |     |   |

| O. COUNTY WICOMICO MARYLAND  | O. STATE DE BURE B. COUNTY SUSSEX   |
|--|---|
| b. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)   | c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)  |
|  | LAURE HOX-  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)  | d. STREET ADDRESS e. IS RESIDENCE   |
| PENINSULA (SENERAL HOSPITAL  | WATERVIEW Drive YES NO TO   |
|  |   |
| 3. NAME OF DECEASED (Type or print) MARY ELIZABETH   | PURNE // DEATH APRIL 27 196 /   |
| 5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   | 8. DATE OF BIRTH 9. AGE (Jn years IF UNDER 1 YEAR IF UNDER 24 HRS.  |
| Female white WIDOWED DIVORCED .  | Sept. 10, 1919   last prithday) Manths Days Haurs Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDU: during most of working life, even if retired)   | STRY 1. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?  |
| HOUSEWICE OUNDOME  | DAPULAND USA  |
| 13. FATHER'S NAME  | 14. MOTHER'S MAIDEN NAME  |
| HANDY COX  | Dolaro Bounds   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO.   | NFORMANT Address  |
| (Yes, no, or unknown) (If yes, give wor or dates of service)   | Topped T Punell JE Loure Do   |
| THE CALLES OF DEATH (Calaboration and and fine for (a) (le) 1 (a) 24   | INTERVAL BETWEEN  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY:  | ONSET AND DEATH   |
| DUE TO   | a, junious menung   |
|  | Della Mellightage   |
| Canditians, if any, which gave rise to immediate (b)   | wellnes of Spiloth  |
| cause (o), stating the under-  | -H. Paralage file Alpania   |
| lying cause last. ) (c) (likely)   | me janened an very comment  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT  | T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS PERFORMED?  YES \( \) NO \( \)  |
| ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH   | D. (Enter nature of injury in Part I ar Part II of item 18.)  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |
|  | ACE OF INJURY (Hame, farm, ctary, street, affice bldg., etc.) (City ar tawn) (Caunty) (State)   |
| 21. I certify that I attended the deceased fram.   | , 19, ta, 19,that I last saw the deceased   |
|  | accurred at 42%. M, fram the causes and on the date stated abave.   |
| drive difference of the control of t | ADDRESS (Street city or town, state)  DATE SIGNED   |
| ACTUAL ( 10 1/50 The sel 11  | Sold of the state |
| SIGNATURE WITH MELTING   | M.D. All duy MA 4 12/6,   |
| PHYSICIAN'S CAMPY IE HEAICH  | V   |
| 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY O  | PCREMATORY 22d. LOCATION (City, town, or county) (State)  |
| BUS, AL H/30/61 ODD Gelle  | ows Com LAURE Del.  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS   | 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  |
| William Coppense Goopan Laurel   | Do / DATE MAY 2 '61 Corling & Krans   |

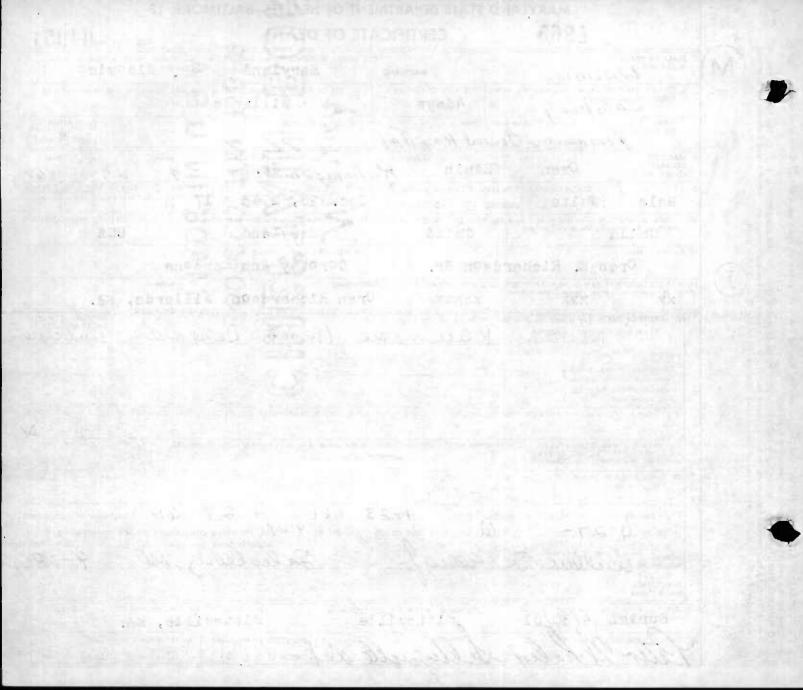
may be retained by the spital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and campletely filled in by the funt page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should the registrar priar to burial, crematian, ar remaval, and in any event within 72 haurs after death. NG PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after d

TO HOSPITAL OR AT VS A1S (4) 1SM 9/SB

THE RESERVE OF THE PARTY OF THE HARRY TEXT TO THE PORT OF THE WAR TO THE TOTAL OF THE PARTY OF THE PAR 16 616101 flor come and the first section 2 JUNE IT WAREL COM Heady Tox Deloca Browds Gernge T. Purish we Laurel Bill 

|    |             |  | MARYI   | AND ST         | ATE DEPART                        | MENT OF HEA   | LTH-BA                     | LTIMORE,                             | 18                |  |
|----|-------------|--|---|----------------|-----------------------------------|---|----------------------------|--------------------------------------|-------------------|--|
|    |             |  | 4963  |                | CERTIFIC                          | CATE OF DEA   | ATH                        |                                      | Reg. Dist. I      | No. (14951                                       |
| M) | 1.          | PLACE OF DEATH   | eem iee   |                | MARYLANI                          | 2. USUAL RESIDENCE                                  | (Where deceas<br>yland     |                                      | tian: Residence b |  |
|    |             | RURAL and give t   | (If autside carporate limi<br>negrest town)<br>/15 bc 24  | ts, write c. L | ength of stay in 11               |   | (If autside carp<br>W111ar |                                      | RURAL and give    | nearest tawn)                                    |
| 32 |             | d. NAME OF HOSP<br>OR INSTITUTION                        | ITAL (If not in haspital, g                               | B              |                                   | d. STREET ADDRE                                     | SS                         |                                      |                   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO          |
|    |             | NAME OF<br>DECEASED<br>(Type ar print)                   | Oren  | Edv            | vin Middle                        | Pichardson  | J. DATE                    | Mc                                   | unth 2 %          | Day Year   |
|    | 5. 9        | Male   | 6. COLOR OR RACE<br>White                                 | 7. MARRIED [   | NEVER MARRIED TO DIVORCED         | 8. DATE OF BIRTH Dec. 26,                           | 1943                       | 9. AGE (In years last pirthday)      | Manths Day        | AR IF UNDER 24 HR                                |
|    | 10a         | during most of To  | ION (Give kind af wark of<br>king life, even if retired   |                | of Business or in                 | DUSTRY 11. BIRTHPLACE (                             | State or foreign<br>yland  | country)                             | 12. CITIZEN       | OF WHAT COUNTRY                                  |
| 7  | 13.         | FATHER'S NAME  | en E. Rich  | ardson         | n Sr.                             | Dor Oth   |                            | Parsons                              |                   |  |
| )  | 15.<br>(Yes | WAS DECEASED EV  | ER IN U. S. ARMED FOR<br>{If yes, give war or dates of so | ervice)        | AL SECURITY NO.                   | Oren Rich   | ards <b>s</b> n            |                                      | rds, M            | d.   |
|    |             |  | immediate DUE TO  | R              | (a), (b), and (c).]               | tie Hea   | it I                       | )esa co                              |                   | NTERVAL BETWEEN NSET AND DEATH                   |
|    | CATION      |  |   | DITIONS CONT   | RIBUTING TO DEATH E               | BUT NOT RELATED TO THE I                            | ERMINAL DISEA              | SE CONDITION G                       | IVEN IN PART 1(c  | 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO          |
| 0  | CERTIFI     | 20a. ACCIDENT W<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY | AS UNDERLYING COME CAUSE OF DEATH Y MEDICAL EXAMINER)     | 20b. DESCRIBE  | HOW INJURY OCCUP                  | RED. (Enter nature of injur                         | y in Part I ar Pa          | art II af item 18.)                  |                   |  |
|    | MEDICAL     | 20c. TIME OF INJU<br>Haur a. m.<br>p. m.                 | 10  | While          | Y OCCURRED 20e. Nat while at wark | PLACE OF INJURY (Hame, factory, street, office bldg | farm, 20f. (Ci             | ty ar tawn)                          | (Caun             | ty) (State                                       |
| 1  |             | 21. I certify tolive on 4.                               | hat I ottended the  | deceosed f     |                                   | 2.3 , 19.6 1 , to oth occurred at 9:                | 20 LM, from                | 1 the couses of Street, city or town | nd on the do      | ow the deceose<br>ote stoted obove<br>DATE SIGNE |
| 0  | 22a         | NAME (Type)  | ON. 22b. DATE THEREC                                      | 0F 22c         | . NAME OF CEMETERY                | OR CREMATORY  | 22d, tOC/                  | ATION (City, tawn,                   | or county)        | (State)  |
|    |             | REMOVAY (Specify   | 4/30/61   | 220            | Pittsvi                           | 1 le  | Pit                        | tsville                              | , Md.             | (aidie)  |
| 12 | 22          | FLINEDAY DIRECTOR  | R'SATIGNATURE /   |                | ADDRESS                           |   | REC'D BY REGIS             | TRAP DAL DEC                         | ISTRAR'S SIGNA    | TUDE   |



funeral TO HOSPITAL OB TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 ppur \$\frac{\pi}{2} \frac{\pi}{2} \text{death}\$. Page 4 may retained by the hospital or attending physician.

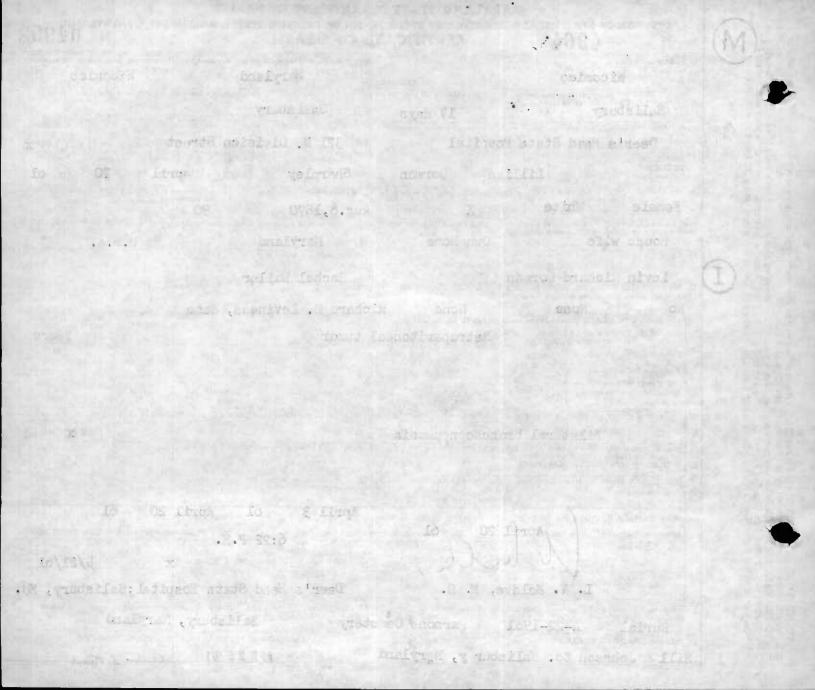
\( \frac{\pi}{2} \frac{\pi}{2} \text{TONERAL DIRECTOR:} \) After this certificate has been signed by the attending physician and completely filled in by the attending physi

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#### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND, 4964 CERTIFICATE OF DEATH

| 7007   |   |                                 |  |  |
|--|---|---------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico   | MARYLAND  | 2. USUAL RESIDENCE              | TE (Where deceased lived, If institution: R land b. COUNTY Williams) | esidence before admission) COMICO      |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury                                     | c. LENGTH OF STAY IN 16                             | c. CITY OR TOWN (III            | f outside corporale limits, write RURAL and <b>ry</b>                | give nearest town}                     |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp   | pital, give street address)                         | d. STREET ADDRESS               |  | a. IS RESIDENCE<br>ON A FARM?          |
| Deer's Head State Hosp   |   |                                 | vision Street  | YES NO X                               |
| 3. NAME OF DECEASED (Type or print) Lillian  | Middle<br>Dorman                                    | Sharpley                        | 4. DATE Month OF April   | 20 19 61                               |
| 5. SEX Female    6. COLOR OR RACE   7. MARRIER   WIDOWEL   | DIVORCED .  | Aug.6,1870                      | 90 yrs.  | Days Hours Min.                        |
| House wife   | nd of business or industr<br>wn Home                | Marylan                         | nd U.S   | ZEN OF WHAT COUNTRY?                   |
| 13. FATHER'S NAME  |   | 14. MOTHER'S MAIDEN             | NAME   |  |
| Levin Richard Dorman  15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (Ifyesgivewarordatesofservice)  No None | SOCIAL SECURITY NO. 17. I                           | Rachel Walnermann Chard D. LeV  | Address  |  |
| Condition if any, which gave rise to immediate cause (a), stating the underlying DUE TO  | ne for (a), (b), and (c).]<br>etroperitoneal        |                                 |  | INTERVAL BETWEEN ONSET AND DEATH YEARS |
| PART II. OTHER SIGNIFICANT CONDITIONS CON Bilateral brone.   | hopneumonia   |                                 |  | 1(a) 19. WAS AUTOPSY PERFORMED? YES NO |
|  | CRIBE HOW INJURY OCCURED  NJURY OCCURRED   200, PLA | . (Enter natura of injury in I  |  | nty) (State)                           |
| Hour a.m. While at work  | Not While fact                                      | ory, street, office bldg., etc. | )  |  |
| 21. I certify that (I) this hospital attended as the deceased alive on April 20  | ded the deceased from                               |                                 | 1901, to April 20, 19.   |  |
| 22a. SIGNATURE   | 11  | ATTENDING A                     | AED. STAFF PHYS.   | 22b. DATE<br>SIGNED<br>4/21/61         |
| 22c. PHYSICIAN'S NAME (Type) L. V. Maldve,   | M. D.   | Deer's He                       | ad State Hospital;S  | alisbury, Md                           |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 4-22-1961   | Parsons Ceme  | tery                            | 23d. LOCATION (City, town or county<br>Salisbury, Marylar            | nd                                     |
| 24 FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbur  | r y, Maryland                                       |                                 | APR 25 '61 Carlung   |  |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

|               | 4  | 965  |                    | CERTIF                    | ICATE       | OF DEAT                                     | H                      |                                      |            | 1)4            | 195       | 3            |
|---------------|--|--|--------------------|---------------------------|-------------|---|------------------------|--------------------------------------|------------|----------------|-----------|--------------|
|               | PLACE OF DEATH<br>a. COUNTY<br>Wico                                    | mico   |                    | MARY                      |             | usual RESIDENCE o. STATE Marylan            | THE NAME OF            | d lived. If institution b. COUNTY    |            |                | e admiss  | ion)         |
|               | b. CITY OR TOWN (III<br>RURAL and give ne                              | outside corporate limit  | s, write           | 3 Days                    | IN 16       | c. CITY OR TOWN Pittsvi                     |                        |                                      |            |                | rest town | ŧ)           |
| 1             | OR INSTITUTION   | AL (If not in hospital, g<br>sula Genera                         |                    | iddress)                  |             | d. STREET ADDRESS                           | S                      |                                      |            |                |           | FARM?        |
|               | NAME OF<br>DECEASED<br>(Type or print)                                 | ALICE  | t                  | Middle<br>PARKER          | SH          | Last<br>OCKLEY                              | 4. DATE<br>OF<br>DEATH | Mon                                  | th<br>4    | 25             | /         | Yeor<br>1961 |
| 5.            | Female   | 6. COLOR OR RACE White   | 7. MARRI<br>WIDOWE | DIVORCED                  |             | ATE OF BIRTH<br>t. 5,1881                   |                        | 9. AGE (In years last birthdoy) yrs. | Months     | 1 YEAR<br>Days | Hours     | Min.         |
| 100           | during most of werk  | ON (Give kind of work of the life, even if retired)              | lone 10b.          | WIND OF BUSINESS OF       | R INDUSTRY  | 11. BIRTHPLACE (S                           |                        | ountry)                              |            | S.A.           | WHATC     | OUNTRY       |
|               | J. Milton  |  |                    |                           |             | 4. MOTHER'S MAIDE<br>Rosanna                |                        |                                      |            |                |           |              |
|               | NO NO DECEASED EVE   | R IN U. S. ARMED FOR<br>If yes, give wor or dates of st          | rvice)             | social security no.       | Mr.         | Everett T                                   | . Shock]               | Ley, Sali                            |            | , Ma           | ryla      | and          |
|               |  | TH [Enter only one co<br>TH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o | 6                  | e for (a), (b), and (c).] | Hen         | l   | × (                    | Sporton                              | , <u>.</u> |                | RVAL BE   |              |
|               | Conditions, if an gove rise to in cause (a), stating lying cause last. | the under-   | 14                 | ypertens                  | ine         | e. J. P                                     | men                    |                                      |            | 2              | en        | 2            |
| CERTIFICATION |  | J (c)  | DITIONS C          | ONTRIBUTING TO DEA        | NTH BUT NO  | T RELATED TO THE TE                         | ERMINAL DISEAS         | SE CONDITION GIV                     | 'EN IN PAR | T 1(a) 1       | PERFO     | AUTOPS'      |
|               | 20a. ACCIDENT WA<br>OR CONTRIBUTING<br>(IF EITHER, NOTIFY              | S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)              | 20b. DESC          | RIBE HOW INJURY OF        | CCURRED. (E | inter nature of injury                      | in Part I or Pa        | rt II of item 18.)                   |            |                |           |              |
| MEDICAL       | 20c. TIME OF INJUR<br>Hour a. m.<br>p. m.                              | Y Month, Doy, Yeo  | While<br>at work   | Not while                 |             | OF INJURY (Home,<br>, street, office bldg., |                        | y or town)                           | ((         | County)        |           | (Stat        |
|               | saw the deceas<br>220. SIGNATURE<br>22c. PHYSICIAN'S                   | I L  | -25<br>~           | 19 <u>, and</u>           |             | ATTENDING PHYS. 22d. ADDRESS                | MED.<br>DIRECTOR       | STAFF PHYS.                          |            | 1              | stated    |              |
| 230           | D. BURIAL, CREMATIO<br>REMOVAL (Specify)                               | Dr. Earl L.  |                    | 23c. NAME OF CEME         | TERY OR C   |   |                        | Maryland TION (City, town,           | or county) |                | (Stot     | re)          |

4-28-61 Burial

Parsons Cemetery

Salisbury, Maryland 256. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill & Johnson Co. Salisbury, Maryland 25a. REC'D BY REGISTRAR MAY 2 '61 DATE

VR A15 (4) 1SM 9/59

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physician

attending

signed

certificate

may be retained by the TO FUNERAL DIRECTOR:

VS A1S (4)

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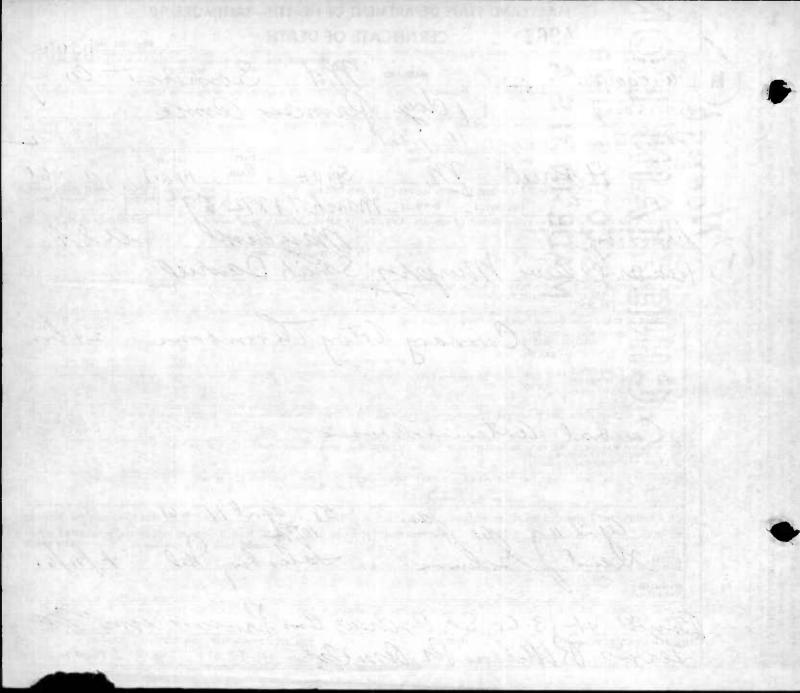
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|                       | IR. C. Section        | 2465                  |                |
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|                       |                       | E K Brokerich         | ALB            |
|                       |                       | E K Broker            | ALE CONTRACTOR |
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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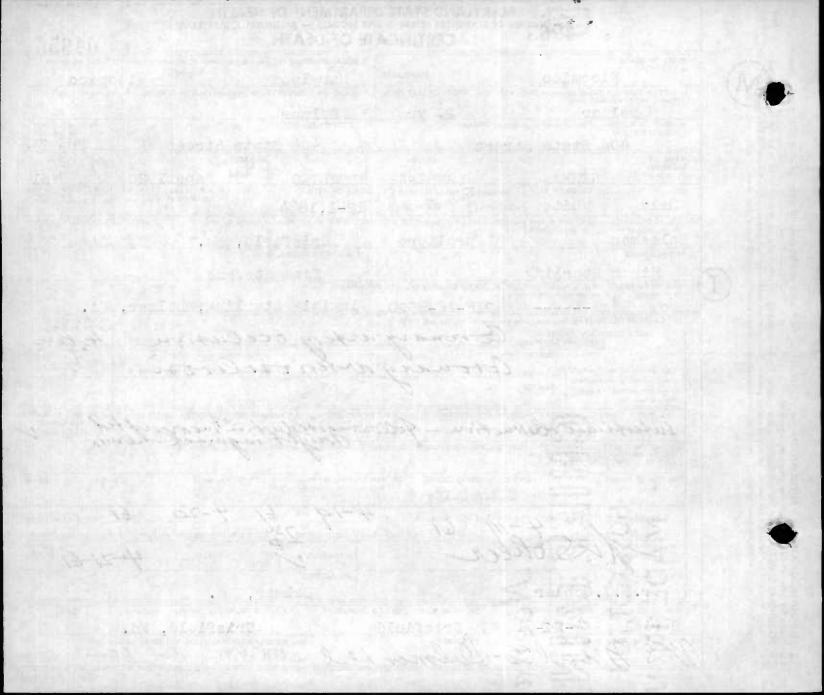
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04958

| 1. PLACE OF DEATH o. COUNTY                         | icomico   |             |              | MARYLAND       | 0        | SUAL RESIDENCE (W. STATE Maryland |                  | d lived. If institut<br>b. COUNT   |            | nce befo  |            | ion)             |
|---|---|-------------|--------------|----------------|----------|-----------------------------------|------------------|------------------------------------|------------|-----------|------------|------------------|
| RURAL ond give n                                    |   | its, write  | c. LENGTH    | OF STAY IN 16  | C        | . CITY OR TOWN (IF                | outside corpo    | prote limits, write                | RURAL ond  | give nec  | arest town | )                |
|   | Mar TAL (If not in hospital,                        | niun stanet | 20           | ) yrs          | A        | Delmar<br>d. STREET ADDRESS       |                  | A THE RES                          |            |           | e. IS RES  | DENICE           |
| OR INSTITUTION                                      |   |             |              |                |          |                                   |                  |                                    |            |           | ON A       | FARM?            |
|   | 4 State S   | Stiree      | et           |                |          | 404 3                             | State            | Street                             |            |           | YES [      | NO               |
| 3. NAME OF<br>DECEASED                              | Fi  | rst         |              | Middle         |          | Last                              | 4. DATE<br>OF    | Mo                                 | nth        | Do        | ly '       | fear .           |
| (Type or print)                                     | HERMAN  |             | LAI          | MRENCE         | SI       | TERLING                           | DEATH            | ADI.T                              |            |           |            | 1961             |
| 5. SEX  | 6. COLOR OR RACE                                    | 7. MARR     | IED NEV      | ER MARRIED     | B. DA    | TE OF BIRTH                       |                  | 9. AGE (In years<br>last birthday) | Months     |           | Hours      | R 24 HRS<br>Min. |
| Male  | White   | WIDOWE      | D 🔲          | DIVORCED 🔲     | 1:       | 2-1,1884                          |                  | 7 6 yrs                            |            | Days      | Hours      | Min.             |
| 10a. USUAL OCCUPATION                               | ON (Give kind of work<br>king life, even if retired | done 10b.   | KIND OF BL   | ISINESS OR IND | USTRY    | 11. BIRTHPLACE (Stot              | e or foreign o   | country)                           | 12. CI     | TIZEN OF  | WHATC      | OUNTRY           |
| Salesman  |   | "           | Furn:        | iture          |          | Crisf                             | ield.            | Md.                                | 5100       | USA       | Δ          |                  |
| 13. FATHER'S NAME                                   | DOMESTIC LINE                                       | -           |              |                | 14.      | MOTHER'S MAIDEN                   |                  | 220.                               |            | U LJZ     | *          | 170              |
| Hinem   | Sterling  |             |              |                |          | Emmo                              | Steve            | an c                               |            |           |            |                  |
|   | ER IN U. S. ARMED FOI                               |             | SOCIAL SEC   | URITY NO. 17.  | INFORA   |                                   | Dreve            |                                    | iress      |           |            |                  |
| (Yes, no, or unknown)                               | (If yes, give wor or dates of                       | service)    |              |                | 77.4     | madada (                          | 74 7 -           | In Da                              | 1          | 3.00      | ,          |                  |
| No  |   |             |              | 5-8520         | . V .    | irginia 8                         | stert.           | ing, De                            | lmar       | -         |            |                  |
|   | ATH [Enter only one of<br>ATH WAS CAUSED BY:        | 1           |              | ), and (c).]   | a        | dono                              | real             | 211                                |            | ONS       | SET AND    | DEATH            |
| 4301  | IMMEDIATE CAUSE (c                                  |             |              | 1              |          | 14                                |                  | 20,70.                             |            | 7         |            | 100              |
| 120   |   | 1           | -            |                | a        | resi-                             | 7 26             | 2                                  |            |           | 7          |                  |
| Conditions, if a                                    | immediate   |             | ,,,,,,       | - Ly           | 00       | 1210                              | We C             | 2104                               | 1          | -         | - (        |                  |
| cause (o), stoting                                  |   | )           |              |                |          |                                   |                  |                                    |            |           |            |                  |
| lying cause lost.                                   |   | c)          |              |                |          |                                   |                  |                                    |            |           |            |                  |
| PART II. OT   | HER SIGNIFICANT CON                                 | NDITIONS C  | CONTRIBUTION |                |          | RELATED TO THE TERM               | MINAL DISEAS     | SE CONDITION GI                    | VEN IN PA  | RT )(o) 1 | PERFO      | RMED?            |
| 3 milest  | rest out  | Nuc         | rou          | /              |          | of winds                          | 4                | in cary                            | 20         | Sul       | YES 🗌      | NO 🔼             |
| PART II. OT LIFE TO CONTRIBUTION (IF EITHER, NOTIFY | AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)     | 20b. DES    | CRIBE HOW    | INJURY OCCUR   | RED. (En | tel noture of Injury in           | n Port for Po    | rt II of item 18.)                 |            |           |            |                  |
| N 20c. TIME OF INJUI                                | RY Month, Doy, Ye                                   | ar 20d. It  | NJURY OCCI   |                |          | F INJURY (Home, far               | rm, 20f. (Cit    | y or town)                         |            | (County)  | - 4        | (Stote           |
| 20c. TIME OF INJUI<br>Haur o. m.                    | 19  | While       | Nat w        | 1116           | foctory, | street, office bldg., e           | tc.)             |                                    |            |           |            |                  |
| ₹ p. m.   |   | of wor      | k of wor     | к Ц            | 11       | -1.28                             | 1                | 450                                |            | -         | -          |                  |
| 21. I certify the                                   | at (I) (this haspita                                | I) attend   | /            | 2              |          | 1                                 | €2ta_            | 1-20                               |            |           | nat (1) (  |                  |
| saw the decea                                       | sed alive on  | 12/9        | عاوا         | and that       | death    | accurred at 2                     | M, fram          | the causes a                       | nd an th   | ne date   | stated     | abave            |
| 220. SIGNATURE                                      | 1000  | till        | x            |                | M.D.     | ATTENDING APHYS.                  | MED.<br>DIRECTOR | STAFF PHYS.                        | 4          | 2/        | 161        | SIGNE            |
| 22c. PHYSICIAN'S                                    |   |             |              |                |          | 22d. ADDRESS                      | J. 1, 2, 1, 2, 1 |                                    |            |           | - 4        |                  |
| Dr L  | V.Sohler  |             |              |                |          | Delm                              | nar, I           | Md .                               |            |           |            |                  |
| 23a. BURIAL, CREMATIC                               |   | O.F.        | Too MALL     | E OF CEMETERY  | 00 000   |                                   |                  |                                    |            |           | (6)        |                  |
| REMOVAL (Specify                                    | ) / ZSD. DATE THERE                                 | _           |              |                |          | MATORT                            |                  | TION (City, town,                  |            |           | (Stat      | e)               |
|   |   | )           |              | isfiel         | d        |                                   |                  | esfield                            |            |           |            |                  |
| 24 TUNERAL DIRECTO                                  | S SIGNATURE   | 18          | ADDRE        | SS             | 1        | 25a. REG                          | PR 25            | TRAR 25b. REG                      | ISTRAR'S S |           |            |                  |
| 11-01-1   | Vanel (   | 11-         | NUL          | men            | - 1      | DATE                              | 近班是中             | 21                                 | alling &   | . / Was   | ICA .      |                  |

TO HOSPITAL OR ATTE VR A15 (4) 15M 9/59



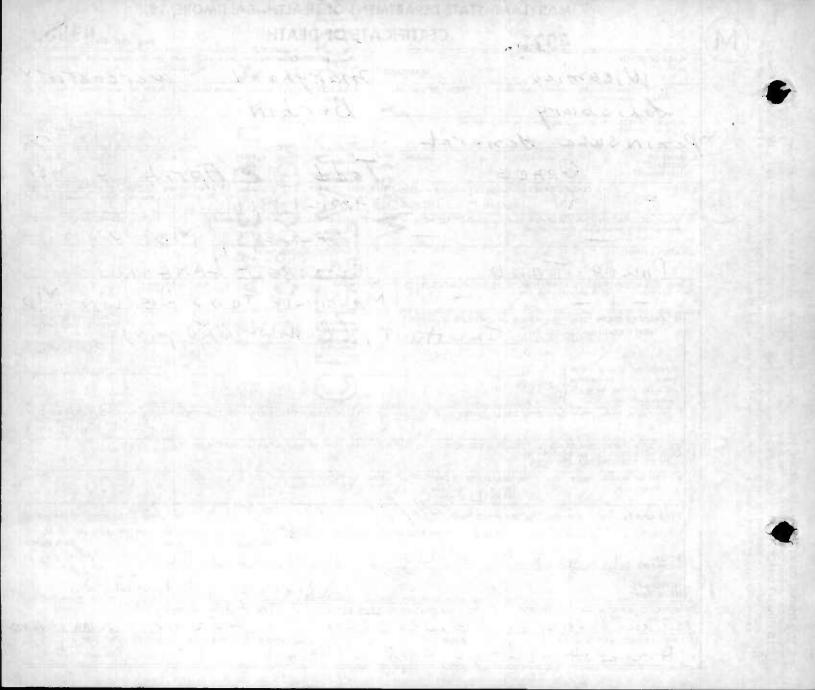
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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| *  | M)  |         | CERTIFICATE OF DEATH  Reg. Dist. No. () 4959   |
|--|-----|---------|--|
| Page director                                      |     |         | PLACE OF DEATH  o. COUNTY  MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  o. STATE  D. COUNTY  MARYLAND  MARYLAND  MARYLAND  D. COUNTY  D |
|  |     |         | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  RURAL and give nearest town)   |
| er de<br>fun<br>ould                               |     |         | Salisbury Berlin   |
| by the   | 162 | 1       | d. NAME OF HOSPITAL (If not in haspital, give street oddress) OR INSTITUTION  EN INSULA Heneral  ON A FARM? YES   NO   |
| 4 hau<br>d in                                      |     | 3.      | NAME OF First Middle Last 4. DATE Month Day Year OF  |
| fille<br>ges                                       | -   |         | (Type or print) OCACE /Odd DEATH APPIL 4 1961  |
| d with   |     | S. :    | 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years last birthdoy) WIDOWED DIVORCED NOVER DIVORCED 9. AGE (In years last birthdoy) WIDOWED NOVER DIVORCED Min.   |
| comp<br>paper<br>eath                              | 9   | 100     | . USUAL OCCUPATION (Give kind of wark done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)  12. CITIZEN OF WHAT COUNTRY?   |
| and and son p                                      |     | 12      | FATHER'S NAME  |
| cark   |     | 13.     | PHILL D TODO   |
| hysic<br>nove<br>nours                             |     |         | WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT Address   |
| ng p<br>e rer<br>72 h                              |     | (16:    | , no, or unknown) (If yes, give war or dates of service) - NRPITICIP TODD BERLIN ND  |
| deoth<br>rendi<br>oleas<br>ithin                   |     |         | 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH   |
| the at   |     |         | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Immstarty & Birthwa 6hogms)   |
| that<br>by th                                      |     |         | DUE TO   |
| ned lermin   |     |         | Garditions, if ony, which gove rise to immediate DUE TO  |
| sit p  |     |         | lying cause lost. (c) (c)  |
| law<br>hysicia<br>s beer<br>Il-tran<br>val, a      |     | MOIT    | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  |
| ng pl<br>e ha:<br>ouria                            | 0   | IIFIC/  | YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)   |
| IAN<br>endi<br>ficat<br>ficat<br>the               |     | CERT    | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |
| HYSIC<br>I or att<br>iis certi<br>use as<br>motion |     | MEDICAL | 20c. TIME OF INJURY Month, Doy, Year Hour o. m.  p. m.  19  20d. INJURY OCCURRED While Not while at work at wo |
| spita<br>er th<br>far                              |     | _       | 21. I certify that J aftended the deceased fram 4/1/6/, 196/, ta 4/3, 196/, that I last saw the deceased   |
| ched   |     |         | alive an 4/2 , 1961, and that death accurred at 455 M, from the causes and an the date stated above.   |
| TOR deto   |     |         | ADDRESS (Street, city or town, stote)  DATE SIGNED   |
| OR had be  | 1   | 1       | SIGNATURE Clifted C. Rolls M.D. Medical Center 43/61.  |
| retain<br>RAL D<br>Shaulo<br>strar p               | - 1 |         | PHYSICIAN'S NAME (Type) Saleabury, Mauyland  |
| HOSP<br>ay be<br>FUNEI                             |     | 220     | BURIAL, CREMATION) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote)  |
| o HO<br>o FUN<br>page<br>the re                    | 3   | 1       | Suind HUGOI EXECTED SEELING KARYLAND   |
| VS A1S (4)<br>1SM 9/S8                             | 0   | 23.     | FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  DATE PR 6 '61  Quellin March 198 6 '61  Quellin March 198 6 '61  Quellin March 198 6 '61  |
|  |     |         | 2082.393×VO  |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



### MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

DAOCO

|  | 2377   | CER   | <b>IFICATE</b>     | OF DEATH   |                        |                                      |                      | (14                           | 300                        |
|--|--|---|--------------------|--|------------------------|--------------------------------------|----------------------|-------------------------------|----------------------------|
| a. COUNTY  | Wicomico   | a N   | AARYLAND 2.        | USUAL RESIDENCE (M                                 |                        | ived. If institution b. COUNTY       |                      | before odmi                   |                            |
| b. CITY OR TOWN<br>RURAL and give                              | (If autside carporate limits, nearest tawn)  Fruitland                     | write c. LENGTH OF S                                      | TAY IN 1b          | c. CITY OR TOWN (IF                                |                        | te limits, write RL                  | JRAL and giv         | re nearest to                 | wn)                        |
| d. NAME OF HOSP<br>OR INSTITUTION                              | Main St  | street address)   | 1                  | d. STREET ADDRESS Main                             | St                     |                                      |                      | ON                            | A FARM?                    |
| R. NAME OF<br>DECEASED<br>(Type or print)                      | First<br>EDW IN  |   | iddle<br>ELD TO    | WNSEND   | 4. DATE<br>OF<br>DEATH | APRI                                 | L ]                  | Day<br>L4th                   | Year<br>19 6:              |
| Male   | White w  |   | ORCED 🔀 O          | et.13,190  | 03                     | AGE (In years last birthday) 57 yrs. | -                    | YEAR IF UNI                   | T                          |
| Retired  | TION (Give kind of work don<br>brigg life, even if retired)<br>Employee (J | H. Dulany   | Son)               | Marion S   | tation                 | ntry)<br>L(Som.C                     |                      | U U                           | S A                        |
| 3. FATHER'S NAME Perry E                                       | dwin Townse  | nd  |                    | 4. Mother's maiden Mary Fra                        | ances T                |                                      |                      |                               |                            |
| S. WAS DECEASED EN   | VER IN U. S. ARMED FORCE<br>(If yes, give war or dates of servi            |   | NO. W. INFO        | Fannie M.<br>Fruitland                             | Townse<br>Mary         | nd(Mot                               | her)                 | Main                          | St                         |
| Canditians, if gave rise to cause (a), statin lying cause last | g the under-   | los   |                    | John Drelante                                      | ic Ho                  | nd Di                                | nen                  | INTERVAL<br>ONSET AN          | ID DEATH                   |
| 5  | VAS UNDERLYING [] 20 IG [] CAUSE OF DEATH I'Y MEDICAL EXAMINER)            | Db. DESCRIBE HOW INJUI                                    |                    |  |                        |                                      | EN IN PART           | 1(a) 19. WA:<br>PERI<br>YES [ | FORMED?                    |
| 20c. TIME OF INJU<br>Haur a. m<br>p. m                         | URY Manth, Day, Year   | N/A  20d. INJURY OCCURRED While Nat while at wark at wark | 20e. PLACE factory | OF INJURY (Hame, far<br>v, street, affice bldg., e | rm, 20f. (City o       | r tawn)  J/A                         | (Co                  | iunty)                        | (Stat                      |
| saw the dece   | nat (I) (this hospital)<br>ased alive on 1 - S                             |   |                    | th accurred 3:0                                    | OP HOW I               | 4-14<br>he causes an                 | , 19.6.1<br>d on the | date state                    | (we) la:<br>ed abave       |
| 220. SIGNATURE   | Early V  | 2mger   | M.D                | ATTENDING SE                                       | MED.<br>DIRECTOR       | STAFF PHYS. Ap                       |                      | 5                             | 226. DATE<br>SIGNE<br>1961 |
| NAME (Type)  | Dr. Earl L.  | Royer   | CELLETEDY OR C     | 407 Came   |                        | . Sali                               |                      | _                             |                            |
| Burial, CREMAT<br>REMOVAL (Specif<br>Burial                    | April 16   | 23c. NAME OF Wicom:                                       | cemetery or c      | orial Par  |                        | ON (City, town, c                    |                      | rland                         | rate)                      |
| OLLOWAY  |  | SALISBURY   | Y MARYI            |  | APR 1 8 '6             |                                      | Lithur S.            | 1 -                           |                            |

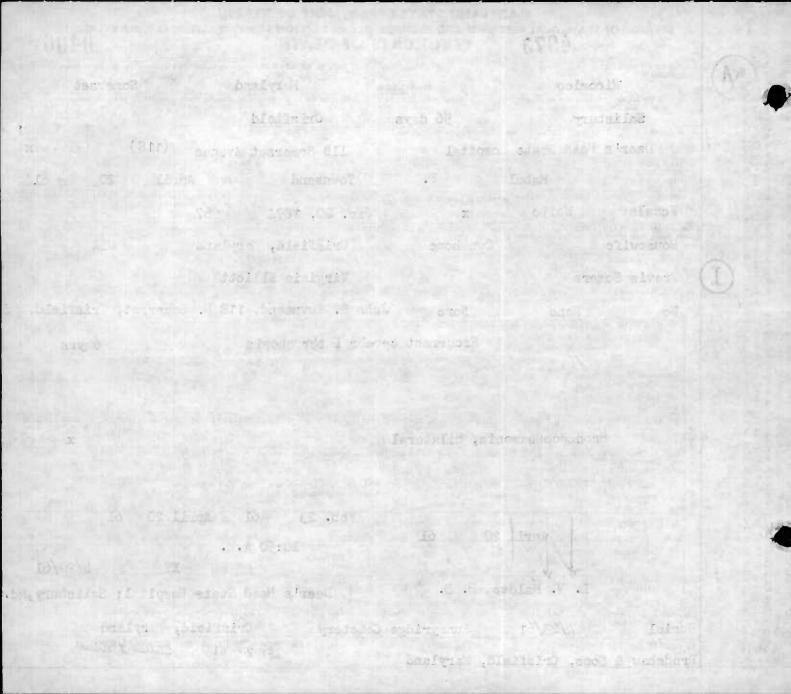
**DEUNERAL DIRECTON.** After this certificate has been signed by the ottending physician and completely filled in by the full page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should the State Board of Health prior to burial, cremation, or removal, and in any event within 72 haurs after death. ING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter d spitol ar attending physician. may be remined by I TO HOSPITAL OR ATT

VR A1S (4) 1SM 9/59

Service assert of the service of the de state (and fell) amount it of mile that The American Street Live and Lie Propert on tooks I Ald French Lie Property

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND () 4973 CERTIFICATE OF DEATH () 4961

| e. COUNTY   |  |  | e, STATE  | NCE (Where decee       | b. COUNTY                                       | 1: Kesidence before edmissio |
|---|--|--|---|------------------------|---|------------------------------|
|   | comico   | MARYLANI                                 | Mar   | yland                  |   | omerset /                    |
| b. CITY OR TOWN (if write RURAL end                                     | outside corporete limits, give nearest fown)                 | c. LENGTH OF STAY IN 1                   | c. CITY OR TOWN   |                        | e limits, write RURAL                           | and give neerest town)       |
| d. NAME OF HOSPIT   | AL OR INSTITUTION (if not i                                  | n hospitel, give street eddress)         | d. STREET ADDRESS   | 5                      |   | a. IS RESIDENCE              |
|   | Head State H   |  |   | set Avenu              |   | YES NO R                     |
| 3. NAME OF<br>DECEASED<br>(Typa or print)                               | Mabel Mabel  | Middle<br>F.                             | Townsend  | 4. DATE<br>OF<br>DEATH | April   | 20 19 61                     |
| 5. SEX Female   | 6. COLOR OR RACE 7. MA                                       | ARRIED NEVER MARRIED OWED MODED DIVORCED | Jan. 20, 189  | la                     | GE (In yeers IF UNDE st birthdey)  Months  Yrs. |                              |
| done during most of wor<br>Housewife                                    | ON (Give kind of work king life, even if retired)            | Own home                                 | Crisfield   |                        |   | USA                          |
| 13. FATHER'S NAME   |  |  | 14. MOTHER'S MAIDEN   | NAME                   |   |                              |
| Travis So   | mers   |  | Virginia :  | Elliott                |   |                              |
| (Yes, no, or unkown) (If  | R IN U.S. ARMED FORCES?<br>yes give were redetes of service) |  | . INFORMANT   | md 110 N               | Address<br>I Company                            | Contactional                 |
| NO LIB CAUSE OF DI  | None   | per line for (e), (b), end (c).]         | ohn S. Townse   | nu, 110 r              | . Domer.Set                                     | I INTERVAL BETWEEN           |
|   | WAS CAUSED BY:   |  |   |                        |   | ONSET AND DEATH              |
|   | MMEDIATE CAUSE (e)   | necurrent ce                             | rebral thrombo  | osis                   |   | 6 yrs                        |
| Conditions, if eny, geve rise to immedia (e), stefing the unceuse lest. | derlying DUE TO  | CONTRIBUTING TO DEATH BUT                | NOT RELATED TO THE TERM   | NINAL DISEASE CO       | NDITION GIVEN IN PA                             | NRT 1(e)   19. WAS AUTOPS    |
| OTA   | Bronchopneumon   | nia, bilateral                           |   |                        |   | PERFORMED?                   |
| 20e. ACCIDENT WA  | S UNDERLYING []   20b.                                       | DESCRIBE HOW INJURY OCCU                 | RED, (Enter neture of injury in                                 | Pert I or Pert II of   | item 1B.)                                       |                              |
| 20c. TIME OF INJUS<br>Hour a.m.<br>p.m.                                 | 19   | While Not While t work et work           | PLACE OF INJURY (Home, fer<br>factory, street, office bldg., et | tc.)                   |   | County) (State)              |
| 21. I certify the   |  | ttended the deceased fro                 |   |                        |   |                              |
| 22e. SIGNATURE  | JUV  | ully                                     | ATTENDING PHYS.   | MED.                   | STAFF<br>PHYS.                                  | 22b. DATE<br>4/20/61         |
| 22c. PHYSICIAN'S<br>NAME (Type)   | L. V. Maldv  | e, M. D.                                 | Deer's  | Head Stat              | te Hospital                                     | l; Salisbury,                |
| 23e. BURIAL, CREMATIC<br>BREMOVAL (Specify)                             | ON, 23b. DATE THEREOF 4/23/61                                | Sunnyridge                               |   |                        | on (City, town or cou                           |                              |
| 24 FUNERAL DIRECTOR   | s signature<br>Sons, Crisfie                                 | ADDRESS                                  | 25e, RI   | PR 2 6 61              | R 25b. REGISTRAR                                | SSIGNATURE                   |



ARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) LACE OF DEATH COUNTY b. COUNTY Wi comi co Somerset MARYLAND and 2 death. b. CITY OR TOWN (if outside corporate limits. E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give neerest town) write RURAL and give nearest town) Salisbury Chance days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give sireel address) d STREET ADDRESS . IS RESIDENCE ON A FARM? Head State Hospital YES NO X papers. 3. NAME OF 4. DATE Month Middle Year DECEASED OF DEATH (Typa or print) Oscar Francis 19 Travers April 67 rbon 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. lest birthday) Months Male White WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY remove (County & State, or foreign country) done during most of working life, even if retired) USA Waterman Seafood Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please and in a Ellen Messick James Travers 16. SOCIAL SECURITY NO. | 17. INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? Address (Yes, no. or unkown) | (If yes give wer or detes of service removal Travers Chance, Grace none Maryland
I INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause (e), (b), end/ ONSET AND DEATH PART I. DEATH WAS CAUSED BY: 110 IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which (b) geve rise to immediate cause DUE TO (a), steting the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) | 19. WAS AUTOPSY CERTIFICATION PERFORMED? 35 0 NO DE 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Pert II of item 1B.) 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Homa, farm, 20f. (City or town) (County) (Stete) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc. Whila Not While Hour a.m. at work at work 21. I certify that (1) (this hospital) attended the deceased from Jan. 31 ...., 1961, to April 1. ...., 19.61 that (1) (we) last 19.61, and that death occured at ...M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE 22a. SIGNATURE SIGNED ATTENDING STAFF 4/4/61 DIRECTOR PHYS. PHYS M.D. death. Page 4
TO FUNERAL director, page to be filed with the 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Head Hospital: Salisbury, Md. Lawry, Lee 23d. LOCATION (City, town or county) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Maryland Chance Rock Creek Cemetery Apr. 6, 1961 24 FUNERAL DIRECTOR'S SIGNATUR 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) Princess Anne, Md. 15M 9/60 DATE 4PR 1 0 '61 arthur S. Maus

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completely

and

physician

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aften

the

by

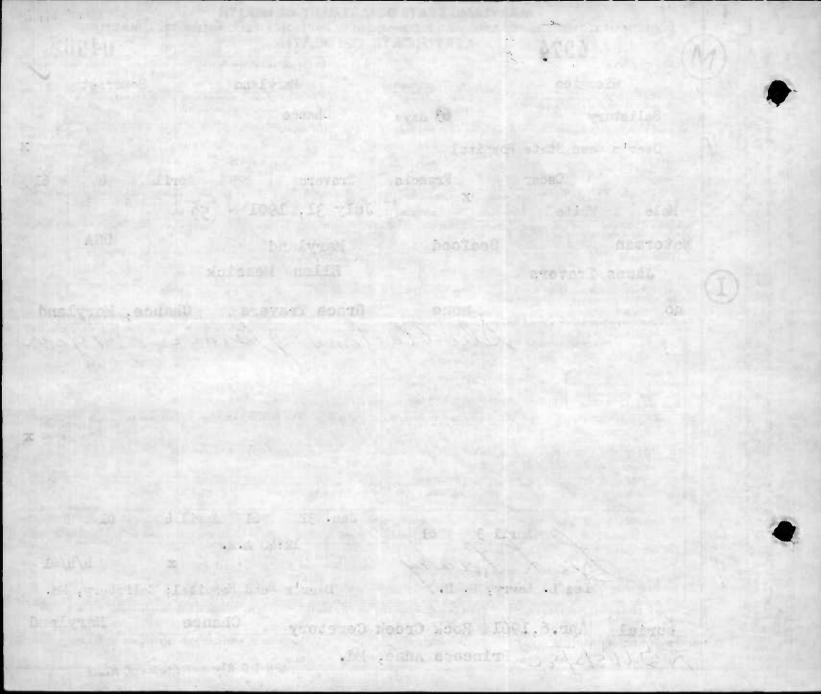
signed

After this certificate

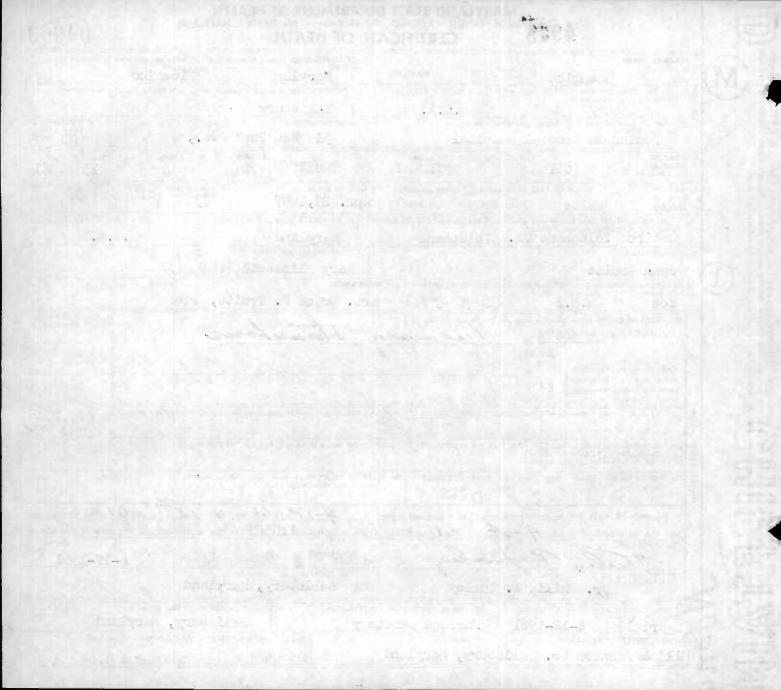
ZOR:

physician.

certificate



|   |  |               |                            |            |                            |           |                |                    |             |           |                       | -                 |
|---|--|---------------|----------------------------|------------|----------------------------|-----------|----------------|--------------------|-------------|-----------|-----------------------|-------------------|
| 1. PLACE OF DEATH<br>a. COUNTY            | Vi comi co   |               | MARYL                      |            | USUAL RESIDENCE STATE Mary |           |                | b. COUN            | TY .        |           | are admiss            | ian)              |
|   | Wicomico   |               |                            |            |                            |           |                |                    | omico       |           |                       |                   |
| b. CITY OR TOWN ( RURAL and give n        | If autside carporate limi<br>earest tawn)              | ts, write     | c. LENGTH OF STAY I        | N Ib       | c. CITY OR TOW             | N (If a   | utside carpoi  | rate limits, write | RURAL an    | d give ne | earest tawr           | 1)                |
| Salisb                                    | · ·  |               | D.O.A.                     | 1/4        | Salis                      | sbui      | CV             |                    |             |           |                       |                   |
| d. NAME OF HOSPI                          | TAL (If nat in haspital, g                             | ive street    |                            |            | d. STREET ADDR             | ESS       |                |                    |             |           | e. IS RES             |                   |
| OR INSTITUTION                            | ula Conomal  | Чол           | nital                      |            |                            |           | York           | ATTO               |             |           |                       | FARM?             |
| Leimis                                    | ula General  | . nos         | hinai                      |            | 217 1                      | MON       | TOIN           | Ave                |             |           | AF2                   | NO 🔼              |
| 3. NAME OF<br>DECEASED                    | Fir  | st            | Middle                     | m          | Last                       | -         | 4. DATE<br>OF  | N                  | anth        | D         | -/                    | Year              |
| (Type ar print)                           | CLYDE  |               | GILBER                     | T          | TRUIT                      | T         | DEATH          |                    | 4           |           | 15                    | 1961              |
| 5. SEX                                    | 16 COLOR OR RACE                                       | 7. MADE       | RIED TO NEVER MARRIE       | N 18 D     | ATE OF BIRTH               |           |                | 9. AGE (In year    | rs IF UND   | ER 1 YEA  | R IF UNDI             | R 24 HRS          |
| 247 - 17                                  |  |               |                            | Λ-         | or. 29,18                  | 227       |                | lan dirthday       | ) Manth     | s Days    | Haurs                 | Min.              |
| Male                                      | White  | WIDOW         | ED DIVORCED                | T 1.7      | 11 0 2/91                  | 001       |                | 1) y               |             |           |                       |                   |
| 10a. USUAL OCCUPATION                     | ON (Give kind af wark of<br>king life, even if retired | dane 10b.     | KIND OF BUSINESS OF        | INDUSTRY   | 11. BIRTHPLACE             | (State    | ar fareign co  | iuntry)            | 12.0        | ITIZEN    | FWHAT                 | OUNTRY            |
|   | Telephone C  |               | Telephone                  |            | Maryla                     | and       |                |                    | - U         | S.A       |                       |                   |
| 13. FATHER'S NAME                         | 20200110110  |               | TOTOPHONE                  | 1/         | I. MOTHER'S MAI            |           | IAAAF          |                    |             |           | •                     |                   |
|   |  |               |                            |            |                            |           | 1              | NOT                |             |           |                       |                   |
| John Tru                                  | itt  |               |                            | 2 3 4      | Mary El                    | ızaı      | betn /         | v hus              |             | 250       |                       |                   |
|   | R IN U. S. ARMED FOR                                   |               | SOCIAL SECURITY NO.        | 17. INFOR  | MANT                       |           |                | A                  | ddress      |           |                       |                   |
| Yes                                       | (If yes, give war or dates of s                        | ervice)       | 2-10-07/2                  | Mrs        | . Grace                    | P.        | Truit          | t. Same            |             |           |                       |                   |
|   | 71 4 77 2 22   | 10/           | 9 10 0 11                  |            | A                          |           |                |                    |             | Love      |                       |                   |
|   |  | use per li    | ne far (g), (b), and (c).] |            |                            | -         | for            | *,                 |             |           | TERVAL BE<br>ISET AND |                   |
| PART I. DEA                               | ATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (or              | )             | ( prima                    | in         | Hara                       | u         | for            | is !               |             |           |                       |                   |
| (1) M                                     | DUE TO   |               |                            | 1          |                            |           |                |                    | 1.15        |           |                       |                   |
| 720                                       |  |               |                            |            |                            |           |                |                    |             |           |                       |                   |
| Canditians, if a                          |  | )             |                            |            |                            |           |                |                    |             |           |                       |                   |
| gave rise to i                            |  |               |                            |            |                            |           |                |                    |             |           |                       |                   |
| lying cause last.                         | (c   | ,             |                            |            |                            |           |                |                    |             |           |                       |                   |
| Z PART II. OT                             |  |               | CONTRIBUTING TO DEA        | TH BUT NOT | RELATED TO THE             | FTERMI    | NAL DISEASI    | E CONDITION (      | SIVEN IN P  | ART 1(a)  | 19. WAS               | AUTOPSY           |
| PART II. OTI                              | TER SIGITIFICATION CONT                                | 51110110      | COTTINIO THE TO DET        |            | NED TO THE                 |           | TANKE DIDEFTO  | 20112111011        |             | ,         | PERFC                 | RMED?             |
| 2   |  |               |                            |            |                            |           |                |                    |             |           | YES [                 | NO 🔀              |
| 20a. ACCIDENT W                           | AS UNDERLYING CONTROL CAUSE OF DEATH                   | 20b. DES      | CRIBE HOW INJURY OF        | CURRED. (E | nter nature af inj         | ury in f  | Part I ar Part | II af item 18.)    |             |           |                       |                   |
| U (IF EITHER, NOTIFY                      | MEDICAL EXAMINER)                                      | 137 H         |                            |            |                            |           |                |                    |             |           |                       |                   |
|   | RY Manth, Day, Ye                                      | 2011          | NUMBY OCCUPATED            | 20- DIACE  | OF INJURY (Hami            | . 60.00   | 206 10:44      | an Annual          |             | (Caunty   |                       | (State            |
| ZOc. TIME OF INJUI<br>Haur a. m.<br>p. m. | ki manin, Day, Te                                      | While         |                            |            | street, affice bld         |           |                | ar rawn)           |             | (County   | 7                     | (Signe            |
| ₽. m.                                     | 19   |               | k at wark                  |            |                            |           |                |                    |             |           |                       |                   |
| Or I continue the                         | -  | N = 44 = in . | J. J. Alex . J             | C          | 1/-12                      | 10        | 61             | 44-1-5             | 10          | 61.       | h-4 /1) /             |                   |
|   |  | orrend        | ded the deceosed           |            | 4-17                       |           |                |                    |             |           | hat (I) (             |                   |
| saw the decea                             | sed olive on   | - 1/4         | 1961, ond                  | that deat  | h occurred of              | T: O      | Mrom           | the couses         | and on 1    | the dat   | e stated              | above             |
| 22a. SIGNATURE                            | - 0  | V             | 1                          |            |                            |           |                |                    |             |           | 22                    | b. DATE<br>SIGNEI |
| 11/1                                      | W.a.   | tu            | stey/                      | M.D.       | ATTENDING PHYS.            | ME<br>DII | RECTOR         | STAFF<br>PHYS.     |             | 4-17      | 7-196                 | 1                 |
| 22c. PHYSICIAN'S                          | P  |               |                            |            | 22d. ADDRESS               | M.        |                | hand               | - 100       | 7         |                       |                   |
| NAME (Type)                               | Dr. Philip   | A. T          | nsley                      |            | Salis                      | bur       | y, Mar         | vland              |             |           |                       |                   |
|   | V  |               | J                          |            |                            |           |                |                    |             |           |                       |                   |
| 23a. BURIAL, CREMATIC                     | ON, 23b. DATE THEREC                                   | )F            | 23c. NAME OF CEME          | TERY OR CR | EMATORY                    |           | 23d. LOCAT     | TION (City, taw    | n, ar caunt | у)        | (Stai                 | le)               |
| REMOVAL (Specify<br>B urial               | 4-18-196   | 51            | Parsons Ce                 | meter      | v                          |           | Sal            | isbury             | Mary        | rland     | 1                     |                   |
| 24. FUNERAL DIRECTOR                      | 7 /  |               | ADDRESS                    |            |                            | DECH      | D BY REGIST    |                    | GISTRAR'S   |           |                       |                   |
|   |  | 7 4 - 1       |                            | and .      |                            |           |                |                    |             |           |                       |                   |
| HITT & JOH                                | mson co. S   | alls          | oury, Maryla               | illu       | DA                         | TE AP     | R 1 9 '        | 01                 | Irthur      | 8. th     | aus                   |                   |



e. IS RESIDENCE

ON A FARM?

YES NO

Year

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15th

Days

SA

(County)

Salisbury, Maryland

arthur S. Kraus

DATE

IF UNDER 1 YEAR IF UNDER 24 HRS.

12. CITIZEN OF WHAT COUNTRY?

Nicholson St

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO K

> > (Stote)

22b. DATE

Manth

YES.

Months

executed within 24 hours after

the death certificate be

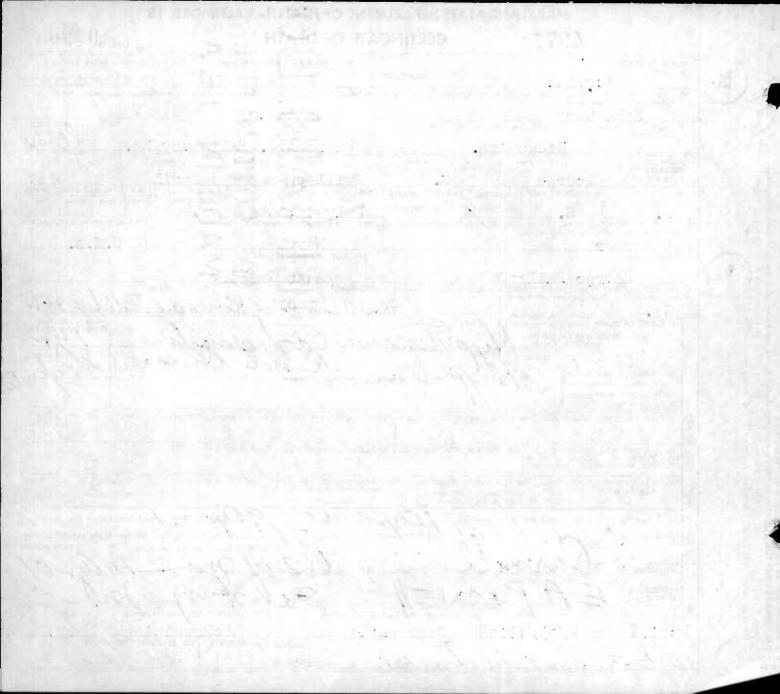
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VR A15 (4) 1SM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| 78 | CERTIFICATE | OF |
|----|-------------|----|
|    |             |    |

|               |  | 1978                                  |                    | CERTIFICA                           | ATE OF E            | DEATH       | 1                          |                            | Reg. Dist.     | No. (       | 14966                     |
|---------------|--|---------------------------------------|--------------------|-------------------------------------|---------------------|-------------|----------------------------|----------------------------|----------------|-------------|---------------------------|
| 1.            | PLACE OF DEATH o. COUNTY Wicomi  | co                                    |                    | MARYLAND                            | O STATE             | dence (who  | ere deceased liv           | ed. If institu<br>b. COUNT | Υ              | before od   |                           |
|               | b. CITY OR TOWN (If outside RURAL and give nearest to Sal  | le corporate limi                     | ts, write          | c. LENGTH OF STAY IN 16  2 1 months |                     |             | utside carporate<br>Oke Ci |                            | RURAL and giv  | e nearest t | 10wn) 4                   |
|               | Springhill   | Sanita                                |                    |                                     |                     |             |                            |                            |                |             | RESIDENCE<br>N A FARM?    |
| 3.            | NAME OF<br>DECEASED<br>(Type or print)   | Hatti                                 | .е                 | Middle<br>M.                        | Walls               |             | 4. DATE<br>OF<br>DEATH     |                            | onth<br>oril   | Day<br>7    | Yeor<br>19 61             |
| 5.            |  | hite                                  | 7. MARRI<br>WIDOWE | DIVORCED DIVORCED                   | 8. DATE OF BIRTI    |             | 881 "                      | AGE (In year ast birthday) | Months D       | YEAR IF UI  | NDER 24 HRS.<br>urs Min.  |
| 100           | during most of working life<br>Housewife   | re kind af wark<br>e, even if retired | dane 10b.          | KIND OF BUSINESS OR INDU            | STRY 11. BIRTHPL    | Mary        |                            | (7)                        |                | ISA         | HAT COUNTRY               |
| 13.           | E. Filmore   | Merri                                 | 11                 |                                     | 14. MOTHER'S        |             | tt E.                      | Clark                      | e              |             |                           |
| 15.<br>(Ye    | WAS DECEASED EVER IN U   | S. ARMED FOR                          |                    |                                     | nformant<br>lliam F | '. Me:      | rrill,                     | 702 S                      | econd          | Stre        | Md.                       |
|               | 18. CAUSE OF DEATH [E<br>PART I. DEATH WA<br>IMME<br>Conditions, if ony, wh<br>gave rise to immedi<br>couse (a), stating the uni | DUE TO                                | , Ke               | rolougit                            | luce                |             | a to                       |                            |                | INTERVAL    | BETWEEN ND DEATH          |
| CERTIFICATION | PART II. OTHER SIG   | ral (                                 | DITIONS/C          | ONTRIBUTING TO DEATH BUT            | ases)               | with        | luces                      | leola                      | EIVEN INPART I | PE          | AS AUTOPSY<br>REFORMED NO |
| MEDICAL CERT  | OR CONTRIBUTING CA<br>(IF EITHER, NOTIFY MEDIC<br>20c, TIME OF INJURY Ma<br>Haur a. m.   | USE OF DEATH                          | or 20d. IN         | NJURY OCCURRED 20e. PL              | ACE OF INJURY (     | Hame, form, | 20f. (City or              |                            | (Cod           | unty)       | (State)                   |
| ¥             | 21. I certify that I calive on   | . 1                                   | decease            | ed from 1/25                        | n occurred at       |             | 1 /                        | ne couses                  |                |             |                           |
|               | PHYSICIAN'S RU   | Hus                                   | 5.(                | FARCHERJ                            | R. 6                | SA          | usbu                       | RY,                        | Md.            |             |                           |
| L             | REMOVAL (Specify) Burial   | 4-9-6]                                | )F                 |                                     | hodist              |             | Po cor                     |                            |                |             | Stote)                    |
| 23.           | FUNERAL DIRECTOR'S SIGN  | IATURE .                              | _ p                | ADDRESS                             |                     |             | BY REGISTRAR               |                            | SISTRAR'S SIGN | 1.4         |                           |

DEUNERAL DIRECTO, where this certificate has been signed by the attending physician and completely filled in by the formation page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filled with the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death. may be retained by 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Pdge 4 VS A15 (4) 15M 9/55

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#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4973 CERTIFICATE OF DEATH Rea. Dist. No with rectar PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed o. COUNTY b. COUNTY MARYLAND 100m1co b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) pe P PURAL and give nearest town) fune should LISB d. NAME OF HOSPITAL (If not in haspital, give street address) e. IS RESIDENCE d. STREET ADDRESS OR INSTITUTION ON A FARM? 72 YES NO ENINSUL pup .⊑ NAME OF 4. DATE Losi Manth Year filled DECEASED Pages DEATH (Type or print) 19 6 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH completely lost birthdoy) Months DIVORCED | WIDOWED 1 popers. 10a. USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR INDUSTRY (State foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) puo de carban after 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician remave 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO **INFORMANT** Address no, or unknown 72 attending please CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO þ ony Conditions, if any, which (b) re hos been signed burial-tronsit permi gove rise to immediate DUE TO couse (o), stoting the underpup physician. lying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY remaval, PERFORMED? NO 13 YES attending 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 1B.) certificote (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, form, 20f. (City or town) 20d. INJURY OCCURRED Day, Year (County) (Stote) 5 factory, street, office bldg., etc.) Hour a. m. While Not while this ot work ot work p. m for 21. I certify that I attended the deceased fram. 19 (1) that I last saw the deceased detached buriol, AM, fram the causes and on the date stated above. that death accurred at and TONERAL DIRECTOR: ADDRESS (Street, city or town, stote) DATE SIGNED 0 pe priar SIGNATURE 3 should PHYSICIAN'S registrar NAME (Type) 220. BURIAL CREMATION. 22b. DATE THEREOF 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY poge EMOVAL (Spedity) 0 23. FUNERAL DIRECTOR'S SIGNATURE 24a, REC'D BY REGISTRAR **ADDRESS** 24b. REGISTRAR'S SIGNATURE

DATE

VS A15 (4) 15M 9/5B

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within 24 hours after

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### MARYLAND STATE DEPARTMENT OF HEALTH

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|        |       | CE           | RTIFIC   | ATE | OF          | DE        | ATH    |      |       |      |

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|                | i i  | 300  |                  | CERTIFIC                               | CATE                  | OF DEATH   |                        |   | 400        | 1          | 140        | 22            |
|----------------|--|--|------------------|--|-----------------------|--|------------------------|---|------------|------------|------------|---------------|
|                | LACE OF DEATH  | comico   |                  | MARYLAI                                |                       | USUAL RESIDENCE (Wo. STATE Marylan   |                        | l lived. If institution b. COUNTY       | -004       | nce before |            | ion)          |
| Ь              |  | outside corporate lim  | its, write       | c. LENGTH OF STAY IN Since 5/5/6       |                       | c. CITY OR TOWN (IF  |                        | rote limits, write R                    | URAL ond   | give ne    | arest towr | )             |
| d              | NAME OF HOSPITA<br>OR INSTITUTION<br>Pine Blut                             | of State   |                  |  |                       | d. STREET ADDRESS  |                        | 19)                                     | X-7        |            | e. IS RES  | FARM?         |
| D              | AME OF<br>ECEASED<br>ype or print)   | Willi  |                  | Middle<br>Ryall                        |                       | lost<br>Webster  | 4. DATE<br>OF<br>DEATH | Mon<br>Apri                             |            | 2          |            | Yeor<br>19 61 |
| S. SI          | Male   | 6. COLOR OR RACE White   |                  | RRIED NEVER MARRIED  VED NOTE DIVORCED |                       | ATE OF BIRTH<br>1y 22, 1878  | В                      | 9. AGE (In years last birthdoy) 82 yrs. | Months     | Doys       | Hours      | Min.          |
| 10a.           | USUAL OCCUPATIO<br>during most of work<br>Waterman                         | N (Give kind of working life, even if retired                  | done 10b         | o. KIND OF BUSINESS OR I               | NDUSTRY               | 11. BIRTHPLACE (Stote Marylan  |                        | ountry)                                 | 12. CI1    | USA        | FWHATC     | OUNTRY        |
| 13. F          | ATHER'S NAME Hi  | ram Webst  | er               |  | 1.                    | . MOTHER'S MAIDEN  Lou:  | NAME<br>isa Wi         | ndsor                                   |            |            |            |               |
| 15. \<br>(Yes, |  | IN U. S. ARMED FOI<br>If yes, give war ar dates of             |                  | s. social security no.                 | 17. INFOR             | ords of P  | ine Bl                 | uff Sta                                 |            | spi        | tal        |               |
|                | Conditions, if or gove rise to in couse (o), stating the lying couse lost. | he under-  | ))<br>))         | Pulmonary T                            |                       |  |                        |   |            |            | 5 y        |               |
| CERTIFICATION  | PART II. OTH   | er significant con   |                  | CONTRIBUTING TO DEATH                  |                       |  |                        |   | VEN IN PA  | RT 1(o)    | PERFC      | RMED?         |
|                | 20c. TIME OF INJURY<br>Hour o.m.   | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)  Month, Doy, Ye | ear 20d.<br>Whil | e _ Not while _                        | e. PLACE              | nter noture of injury in<br>OF INJURY (Home, far<br>, street, office bldg., et | m, 20f. (City          |   |            | (County)   | )          | (Stote        |
|                | 21. I certify tha<br>saw the deceas<br>220. SIGNATURE                      | t (I) (this hospita  | l) atter         | nded the deceased fr. 22 1961, and the | om <u>Ma</u> nat deat | h accurred at  | 4a                     | April 24 the causes an                  |            |            | e stated   |               |
| 230            | 22c. PHYSICIAN'S<br>NAME (Type)  |  |                  | gs, M.D.                               | RY-OR-FI              | 22d. ADDRESS<br>Salis  | sbury,                 | Marylai                                 |            |            | (Sto       |               |
|                | REMOVAL (Specify)  SULLIAN  UNERAL DIRECTOR'                               | 4-26-  | 61               | 54. Paul                               | s Ce                  | melery   | D BY REGIST            | VENOS                                   | ISTRAR'S S | ,          | med        | 7.            |
|                | Lero   | y Webs   | ter              | - DEal J.                              | la                    | I he DATE  |                        |   | Irilay.    |            |            |               |

MASSICATION STATEOUS ANAGEST OF REASES Daga Service of the servic demon likelater that the

FOR STATE HEALTH DEPT TO DEPUTY MED. IL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is the please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your filles. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board or Tealth or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

#### MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14969

| 1.            | PLACE OF DEATH   |  | 2. USUAL RESIDEN  | ICE (Where deceases      | d lived, If Institution: R             | esidence before admission) |
|---------------|--|--|---|--------------------------|--|----------------------------|
|               | Wicomico   | MARYLAND   | a. STATE Mo   | rvland                   | b. COUNTY WOT                          | cester /                   |
| )  -          |  | IGTH OF STAY IN 16   |   | U                        | limits, write RURAL and                |                            |
|               | write RURAL end give nearest town)                                     |  |   |                          | 1                                      | 2 V 2                      |
| _             | Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give | n street a delegas)  | Berlin  |                          | d                                      | I e. IS RESIDENCE          |
|               | a  |  |   | 44                       |  | ON A FARM?                 |
| 1             | Peninsula General Hospi  |  | Route   | # 2                      |  | YES NO                     |
| 3.            | NAME OF First DECEASED   | Middle   | Last  | 4. DATE                  | Month                                  | Dey Yeer                   |
|               | (Type or print) Frank Charles  | Widdow   | vson  | DEATH                    | 4-30-61                                | 19                         |
| 5.            | SEX 6. COLOR OR RACE 7. MARRIED NE                                     | VER MARRIED X 8  | . DATE OF BIRTH   |                          | (In years   IF UNDER 1                 |                            |
|               | M WIDOWED  | DIVORCED -   | JUNE 17,1   | 194/ 20                  |  | Days Hours Min.            |
|               | a. USUAL OCCUPATION (Give kind of work   10b. KIND OF B                | SUSINESS OR INDUSTR  | Y   11. BIRTHPLACE (State                                 | e or foreign country)    | 12. CITI                               | ZEN OF WHAT COUNTRY?       |
| a             | one during most of working life, even if retired)                      | EGE  | POINC   | ESS AIV                  | NEMA                                   | 11 5-17                    |
| 13            | . FATHER'S NAME  | . 0 0-0  | 14. MOTHER'S MAIDEN                                       |                          | ······································ | 0, 5-1                     |
|               | For a ANI - and  | 2.1  | B   | . 000                    |  |                            |
| 1 15          | WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL                   |  | NEGRMANT  | 1 HUM                    | Address                                |                            |
| (1)           | es, no, or unkown)   (If yes give war of detes of service)             | SECORITI NO. IV. I   | T 17 1  |                          | Address                                | N                          |
| -             | NO 1110  | ]  | R, I-H. W   | LIDDO                    | NSON R                                 | GRUIN I'I                  |
|               | 18. CAUSE OF DEATH Enter only one ceuse per line for (e                | ), (b), and (c).]  |   |                          |  | ONSET AND DEATH            |
|               | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H7201                 | ture of s  | ku11  |                          |  | Sudden                     |
|               | DUE TO   |  |   |                          |  |                            |
|               | Conditions, if eny, which (b)  |  |   |                          |  | Carolina and               |
|               | gave rise to immediate cause   |  |   |                          |  |                            |
|               | (e), stating the underlying  |  |   |                          |  |                            |
| z             | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION                     | IG TO DEATH BUT NO   | T RELATED TO THE TERM                                     | INAL DISEASE COND.       | ITION GIVEN IN PART                    | 1(a) 19 WAS AUTOPSY        |
| 음             |  |  |   |                          | THOU STATE OF THE PARTY                | PERFORMED?                 |
| 1 5           | 20- EVTERNAL CAUSE WAS 201 DESCRIPE HOW                                | INITION OCCUPED (  |   | add as Boat Hadden       | 0.1                                    | YES NO                     |
| CERTIFICATION | PRIMARY OF CONTRIBUTING  | INJURY OCCURED. (E   | inter neture of injury In Pe                              | or i or ran ii or iiem i | 8.)                                    |                            |
|               | CAUSE OF DEATH. Driving  | motorcy  | cle and co  | ollided v                | with a po                              | ny.                        |
| MEDICAL       |  |  | CE OF INJURY (Home, far<br>ory, street, office bldg., etc |                          | wn) (Cour                              | ty) (State)                |
| ME            |  | 44111110   | hway  | Berli                    | in Worce                               | ster Md.                   |
|               | 21. I certify that I took charge of the remains de                     |  |   | Inspection 7             | Inquiry X.                             | and in my opinion          |
|               | death resulted from: Natural causes . Acc                              | ident 🕶 . Suici  | present .   |                          | mined manner                           |                            |
| 1             |  |  | CHIEF MEDICAL   | _                        |  |                            |
|               | ACTUAL &   |  |   | DICAL EXAMINER           | ,                                      | DATE SIGNED                |
|               | SIGNATURE  |  | M.D.  | 1000                     |  |                            |
|               | examiner's Earl L. Royer, M.   | .D.  |   | AL EXAMINER X            | 5-1-                                   | <b>6T</b>                  |
| 22            | BURIAL CREMATION 225. Camden Ave.                                      | Saliabur   | Address (Street,  | city, town, or county    | )<br>City, town, or country)           | (State)                    |
| 1             | KENOVAL (Specify)  | and the same of th |   |                          |  | V1.                        |
| -             | 12081001 - 141011 -  |  |   | SERL                     |  | 1-110                      |
| 2:            | 3. FUNERAL DIRECTOR BLAND  | DRESS  | 14 / 240. RE  | MAY 5 61                 | 24b. REGISTRAR'S SIG                   | SHATURE S. Timus           |
|               | ome of our tyle of   | rue 1  | DATE  | ,,,,,,                   |  |                            |

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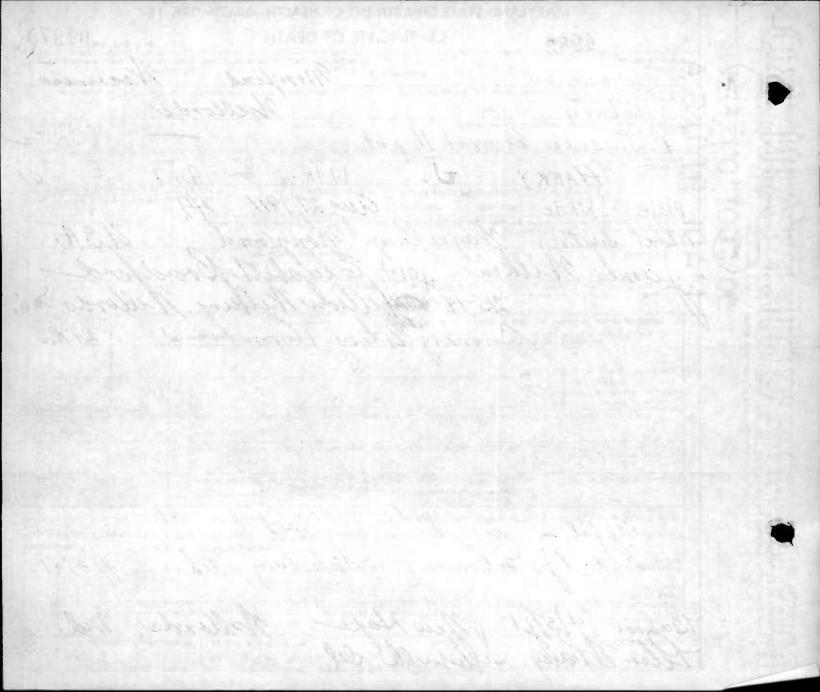
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# MADVIAND STATE DEDADTMENT OF HEALTH

| MARIEMIN STATE DEL ARTMENT ST TIENETTI  |             |
|---|-------------|
| SION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE                      | 1, MARYLAND |
| SION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE CERTIFICATE OF DEATH | 04971       |

1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. COUNTY b. COUNTY Maryland Wicomico Wicomico MARYLAND b. CITY OR TOWN (if outside corporete limits. c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) c. LENGTH OF STAY IN 16 writa RURAL and give nearast lown) Salisbury 160 days Salisbury d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? 1507 Laurel Drive Deer's Head State Hospital YES NO 3. NAME OF 4. DATE Middle DECEASED Mary Wilkinson Ellem April DEATH 19 61 (Type or print) 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In yeers | IF UNDER 1 YEAR) IF UNDER 24 HRS. last birthdey) Female WIDOWED 1879 DIVORCED T 10a. USUAL OCCUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) House Work -Retired Wicomico County Md. None 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Isaac Hearn Ellen Henry 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. Wilkinson (Son) 1507 Laurel Dr. (Yes, no, or unkown) | (If yes give wer or detes of service) Salisbury, Maryland 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN I. DEATH WAS CAUSED BY: Hypertensive arteriosclerotic cardiovascular dis. Years IMMEDIATE CAUSE (e) DUE TO Conditions, if env. which geve rise to immediate cause DUE TO (a), stating the underlying PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Old cerebral thrombosis NO 2Da. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 2Db, DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Pert I or Part II of item 18. (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d, INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 2Df. (City or town) (County) (Stata) 20c. TIME OF INJURY Month, Dey, Yeer factory, street, office bldg., etc.) While Not While N/A el work et work p.m. saw the deceased alive on April 11 1961 and that death occurred at 1961 P.M. from the causes and on the date stated above. 22b. DATE 22e. SIGNATURE 4/12/61 SIGNED ATTENDING DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) V. Maldve, M. D. ead State Hospital; Salisbury, Md. 23d. LOCATION (City, town or county) 23a. 8URIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Specify)
Burial Apr. 14.1961 Spring Hill Memory Gardens-Salisbury, Maryland 250, REC'D BY REGISTRAR | 256, REGISTRAR'S SIGNATURE **ADDRESS** 24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY Civiling & Traces

funeral pue .⊑ papers. and certificate physician remove please death attending the 0 certificate ha as o prior ed for the After this TOR: death. Page 4 may director, be filed OH VR A15 (4)

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The law requires that the death certificate be executed within 24 fours after ratending physician. 5. 10a. TO HOSPITAL ON TTENDING PHYSICIAN: death. Page 4 may a retained by the hospital or TO FUNERAL DIRECTOR: After this certificate h. CERTIFICATION MEDICAL director, page 3 should be be filed with the State Dept 11 Mulh DIRECTOR M.D. 22d. ADDRESS 22c. PHYSICIAN'S L. V. Maldve, M. D. NAME (Type) Head Hospital; Salisbury, Md. 23a. BURIAL, CREMATION, 23b. DATE THEREOF BUTIA 1 4/27/61 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery Crisfield, Maryland 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 9/60 Bradshaw & Sons, Crisfield, Maryland DATE

| DIVISION O                                 |   |                     |                                |           | ARTMENT O  |                |   | RE 1, M        | ARYLANI                                   |                       |  |  |
|--|---|---------------------|--------------------------------|-----------|--|----------------|---|----------------|---|-----------------------|--|--|
|  | 4984  |                     | CERTIFI                        |           |  |                |   |                | 114                                       | 972                   |  |  |
| LACE OF DEATH                              |   |                     |                                |           | 2. USUAL RESIDEN   | CE (Whare d    | lecaased livad, if                            | institution: R | esidenca befo                             | ra admission)         |  |  |
|  | icomico   |                     | MARY                           |           | a. STATE   | and            | b. COUN                                       |                |   | V                     |  |  |
|  | outside corporata limit                               | s.                  | c. LENGTH OF STA               |           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |                |   |                |   |                       |  |  |
| Salisbu                                    | giva naarast town)                                    |                     | 685 da                         | 73        | Crisfie  |                | points ittilia, with                          | - /            | 9 X                                       | -2                    |  |  |
|  | Head State  |                     |                                | ess)      | RFD # 1  |                |   |                | IS RESIDENCE     ON A FARM?     YES NO TO |                       |  |  |
| IAME OF                                    | First   | -10 Op              | Middle                         |           | Last   | 4. DATE        | Monti   | h              |   | Yaar                  |  |  |
| YPE or print)                              | None  |                     | T                              |           | 1729   | OF<br>DEATE    |   |                |   |                       |  |  |
| EX   | Nanc  | J                   | Jane                           |           | Wilson   |                | Apri  |                |   | 19 61                 |  |  |
| Female                                     | 6. COLOR OR RACE White                                | 7. MARRIE<br>WIDOWE |                                |           | an. 1. 1878  |                | 9. AGE (In years<br>lest birthday)<br>83 yrs. | -              | Days Hour                                 | DER 24 HRS.  Min.     |  |  |
|  | ON (Give kind of work                                 |                     | ND OF BUSINESS OF              |           |  | nty & Stete, o | r foreign country)                            | 12. CITI       | ZEN OF WHA                                | T COUNTRY?            |  |  |
| Seamstres                                  | king lifa, aven if retired<br>SS                      |                     | rment                          |           | Crisfield,   | Maryl          | and   | 1              | USA                                       |                       |  |  |
| FATHER'S NAME 14. MOTHER'S MAIDEN NAME     |   |                     |                                |           |  |                |   |                |   |                       |  |  |
| Dow Byrd                                   |   |                     |                                |           | Rachel Ste   | rling          |   |                |   |                       |  |  |
|  | R IN U.S. ARMED FORCE yes givawar or dates of sa None | rvica)              | SOCIAL SECURITY N<br>2-10-4915 |           | vood Wilson,   | 116 0          | Address                                       |                | isfield                                   | d. Md.                |  |  |
| 8. CAUSE OF DE                             | EATH [Enter only one                                  | cause per l         | ne for (a), (b), and (         | :).]      |  |                | •   | -              | INTERVAL                                  | BETWEEN               |  |  |
|  | WAS CAUSED BY:<br>MMEDIATE CAUSE (a)_                 | A                   | rterioscl                      | erosi     | s, general   |                |   | 367            | Jean:                                     |                       |  |  |
| , , ,                                      | O DUE TO  |                     |                                |           |  |                |   |                | 150                                       |                       |  |  |
| Conditions, if any,                        |   |                     |                                |           |  | البخائب        |   |                |   |                       |  |  |
| gava risa to immadia<br>a), stating tha un | PATER TO  |                     |                                |           |  |                |   |                | 120%                                      |                       |  |  |
| ausa last.                                 | (c)   |                     |                                |           |  |                |   |                |   |                       |  |  |
| PART II. OTHER                             | SIGNIFICANT CONDIT                                    | ONS CON             | TRIBUTING TO DEAT              | H 8UT NOT | RELATED TO THE TERMIN  | NAL DISEASE    | CONDITION GIV                                 | EN IN PART     |   | S AUTOPSY<br>REORMED? |  |  |
|  | S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)        | 20b. DES            | CRISE HOW INJURY               | OCCURED.  | (Entar natura of injury in   | Part I or Part | ll of item 18.)                               |                |   |                       |  |  |
| 20c. TIME OF INJUR<br>Hour a.m.<br>p.m.    | Y Month, Day, Yea                                     | While               |                                |           | CE OF INJURY (Homa, farm<br>ry, streat, offica bldg., etc                        |                | y or town)                                    | (Cour          | ity)                                      | (Steta)               |  |  |
| 1. I certify th                            | at (b) (this hospita                                  | l) attend           | ded the decease                | d from    | June 9   | 19.59 to       | April   | 24 106         | 51 that (1)                               | (wa) last             |  |  |
|  |   |                     |                                |           |  |                |   |                |   |                       |  |  |
| 228. SIGNATURE                             |   | /                   | 1                              | and midi  | death occured at   | 45 P.M         | CTAFF   | and on II      | a date 218                                | 22b. DATE             |  |  |

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